CHANGE OF MIND
THERAPEUTIC SOLUTIONS

Change of Mind -Therapeutic Solutions Counselling Services

Referral Date: _____

REFERRAL REQUIRED:

☐ Individual Counselling	☐Clinical Psychologist	☐Psychologist
☐ Group Counselling	☐Mental Health Social Worker	☐ Any available worker

PATIENT DETAILS

Title:		Surname:		First Name:	
D.O.B:				Gender:	
Address:				Post Code:	
Phone:				Mobile:	

Country of Birth:					
Aboriginal:	YES	NO	Torres Strait:	Yes	No
First Language			Interpreter Required?	Yes	No
Next of Kin:					
Phone:			Mobile:		

INFORMAL SUPPORTS

Person	Relationship

FORMAL SUPPORTS

Agency	Services/Treatment Provided

REFERRALS DETAILS

GP Name				GP STAMP
GP Practice				
Address				
Suburb		Postcode		
Contact No				
Email				
Fax				

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GP MENTAL HEALTH TREATMENT PLAN		
	MBS Item Numbers	
Clinical Psychologist	80000, 80005, 80010, 80015, 80020	
Psychologist	80100, 80105, 80110, 80115, 80120	
MH Social Worker	80150, 80155, 80160, 80165, 80170	
Presenting Issues *What are the patient's current mental health issues*		
Mental Health History		
Medications		
Mental State Examination Results		
Mental Health Diagnosis		
Patient Goals		
Focused Psychological Intervention (Preferred/Required)	☐ Cognitive Behaviour Therapy ☐ Narrative Therapy ☐ Skills Training ☐ Relationship Building ☐ Parenting ☐ Other:	☐ Dialectal Behaviour Therapy ☐ Relaxation/Mindfulness ☐ Psycho-education ☐ Family Counselling ☐ As determined by clinician

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RISK ASSESSMENT

Risk Assessment	Ideation	Thoughts	Plan
Suicide			
Self-Harm			
Harm to Others			
Other:			

DRUG AND ALCOHOL (AoD)

Past AoD Use:	
Current AoD Use:	

FORENSIC HISTORY

Past Convictions:	
Current/Pending Convictions:	

CONSENT

Patient Consent			
I _____ have discussed all aspects of my assessment/plan with my GP and agree to my referral to Change of Mind – Therapeutic Solutions. I agree to my health information being shares with Change of Mind. We have agreed to review the plan on _____ (DD/MM/YYYY).			
Signature		Date	

GP Consent			
I _____ have discussed the all aspects of the above assessment/plan and referral to Change of Mind – Therapeutic Solutions with my patient. We have agreed to review the plan on _____ (DD/MM/YYYY).			
Signature		Date	