

**Gold Coast Primary Health Network**

**Psychological Services Program**

**Provisional Referral (not for GP use)**

**Referral Pathway – Child (0-12) – PROVISIONAL REFERRAL**

The Psychological Services Program provides free short term psychological interventions for children with moderate mental health disorders, or for children that may be **at risk** of developing a mental health disorder, childhood behavioural or emotional disorder.

The Psychological Services Program offers clients counselling/psychology sessions with an approved Psychological Mental Health Professional; Psychologist, Mental Health Social Worker, Nurse or Occupational Therapist.

**Eligibility Criteria**

Eligible clients (or parent/carer) may hold either a current health care or pension card, or be experiencing financial disadvantage, and can benefit from short term psychological intervention.

Clients can now receive Better Access (Medicare) funded psychological sessions in the same calendar year.

**How to access the Psychological Services Program**

To simplify the process and enable timely access to services, Provisional Referrals into the Psychological Services Program can be **made directly by a School Principal or Deputy Principal, School Guidance Officer or a Child Care Centre Director**. A Provisional Referral form is completed only after determining the client’s eligibility for the Program and obtaining written consent of the Parent/Carer.

This form is then emailed to PCCS (Intake) at [**GCTX@pccs.org.au**](mailto:GCTX@pccs.org.au) or fax **07 3186 4099**. The Psychological Services provider will contact the client’s parent/carer to discuss this referral within 2 business days.

**\*\*Important - The client must visit their regular General Practitioner (GP) within 2 weeks of this referral, to have a Psychological Services Referral and Child Treatment Plan.**

**For further enquiries about the Psychological Services Program please contact PCCS**

**Phone: (07) 3186 4000 Email:** [GCTX@pccs.org.au](mailto:GCTX@pccs.org.au) **or visit** [**www.healthygc.com.au**](http://www.healthygc.com.au)

**Referral Process:**

1. Assess the client and determine if they have, or are at risk of developing a mental health disorder, childhood behavioural or emotional disorder.

2. Confirm client (or child’s parent/carer) holds a current health care or pension card, or is financially disadvantaged.

3. Obtain client (or child’s parent/carer’s) consent for referral and sharing of information.

4. Complete this Provisional Referral form and email to GCTX@pccs.org.au or fax to **(07) 3186 4099.**

5. Advise client they are still required to attend an appointment with their regular GP for a Psychological Services Referral and a Child Treatment Plan. This needs to occur within 2 weeks of this referral.

6. Advise client they are only able to access two (2) sessions with an approved Psychological Services Mental Health Professional, until they visit their GP for a Psychological Services Mental Health Referral and a Child Treatment Plan. When the GP referral is received, further sessions can be accessed up to a total of 6.

7. The Referrer completing this referral must also sign (*see below*), and provide a daytime contact phone number.

**Referral Pathway – Child (0-12)**

**PROVISIONAL REFERRAL**

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Person completing referral: | | | Date: |
| Discipline of referrer: 🗌 School Principal or Deputy Principal 🗌 Guidance Officer  🗌 Child Care 🗌 Centre Director  (One must be ticked) | | | |
| Workplace of referrer: | | | |
| Phone: | Fax: | Email: | |
| I the above named believe this client meets the eligibility criteria for the Psychological Services Program, as set out on page one (1), and the client has been advised that final acceptance into the Psychological Services Program will require a GP referral and child treatment plan. | | | |
| **Signature of person completing the referral:** | | | |

**Client Details:**

|  |  |  |
| --- | --- | --- |
| Client Name: | | D.O.B: |
| Parent/Carer Name: | Mobile: | |
| Daytime Contact Number: | | |
| Address: | | |
|  | | Postcode: |
| **Contact Details of Client’s regular GP:** | | |
| GP Name: | | |
| Practice Name: | | Phone Number: |
| Address: | | |
|  | | |
|  | | Postcode: |
| Does the client speak a language other than English? 🗌 Y 🗌 N | If yes, what language: | |
| If yes, how well does the client speak English? | 🗌 Very Well 🗌 Well 🗌 Not Well 🗌 Not at all | |
| Does the client identify as Aboriginal or Torres Strait Islander? | 🗌 No 🗌 Aboriginal 🗌 Torres Strait Islander 🗌 Both | |
| Health Care/ Pension Card No: | Expiry Date: | |
| As part of your assessment of the patient, do you consider them financially disadvantaged? 🗌 Y 🗌 N | | |
| Does the client have access to transport? 🗌 Y 🗌 N  \**If No is selected, aTele-Mental Health service is available to provide mental health and allied health service via technology such as videoconferencing.* | | |
| **Would the client (or parent/carer) prefer to** **receive** **services via telehealth**? 🗌 Y 🗌 N | | |

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| Presenting issues and reason for this referral: |

|  |  |
| --- | --- |
| **Consent:**  I consent to the sharing of information, relevant to my Child’s referral and treatment, between the Referrer, Gold Coast Primary Health Network, PCCS, my GP and the Psychological Services Mental Health Professional allocated my referral.  I understand that this referral will be provided to a GCPHN Psychological Services provider and I will be contacted within two (2) working days for an appointment.  Any information collected from clients will be stored according to each organisation’s strict privacy and confidentiality policies. | |
| Client’s (Parent/Carer’s) Signature: | Date: |
| Name of Parent/Carer | |

**Please forward this referral to the PCCS Intake Team:**

**Secure Fax: 07 3186 4099 Email:** [GCTX@pccs.org.au](mailto:GCTX@pccs.org.au) **Phone: 07 3186 4000**