

# Gold Coast Primary Health Network

## Psychological Services Program

### Exceptional Circumstances Referral Form

Forward completed Exceptional Circumstances Referral Form via Medical Objects to: *GCPHN Referrals*  
or to the PCCS Intake Team: Secure Fax: **07 3186 4099**  
GP's, Paediatricians and Psychiatrists can call (07) 3186 4000 for service information.

#### WHAT ARE EXCEPTIONAL CIRCUMSTANCES?

**Exceptional Circumstances** are defined as:

- a significant change in the individual's clinical condition or care circumstance where ceasing treatment would lead to a detrimental outcome for the patient, which makes it appropriate and necessary to increase the maximum number of occasions of service, or
- where there is a clinical need for a patient to access a second or third block of suicide prevention sessions in one calendar year.

GPs, Paediatricians and Psychiatrists should be guided by their professional ethics and/or Code of Conduct to determine that the patient meets the above requirements.

#### HOW TO REFER UNDER EXCEPTIONAL CIRCUMSTANCES

Before completing this Exceptional Circumstances Referral Form, please refer to the Mental Health Professional's report outlining information on assessments, treatment provided, outcomes and recommendations on future management for the patient.

When completing the **Exceptional Circumstances Referral Form** consider whether the patient's significant change in clinical condition, care circumstances or reasons why ceasing treatment will lead to a detrimental outcome. Consider if any other treatment pathways are available for the patient.

Referral Date:

#### **Patient Details**

Patient Name:

DOB:

Address:

Postcode:

Home Ph:

Mobile Ph:

**A CURRENT Health Care/Pension Card is mandatory to access the Psychological Services Program. It is not required for other PHN programs.**

Health Care/Pension Card Number:

Expiry date:

#### **Referrer Details**

Referrer's Name:

Referrer's Email:

Practice Name:

Provider Number:

Practice Ph:

Practice Fax:

Practice Address:

Post Code:

Referrer's Signature:

#### **Referral Details**

Have you received and reviewed the report from the Mental Health Professional following the initial sessions?

Yes

No

*\* If No is selected, please contact the Mental Health Professional for the report prior to making this referral.*

Have you considered a psychiatric review? If not, why is this not appropriate?

Yes

No

Outline below the exceptional circumstances relevant for this referral – for suicide prevention referrals, please attach risk assessments undertaken by the GP/referrer to determine the need for further suicide prevention psychological sessions. **(If no risk assessment is attached this referral won't be accepted. This will delay the intake process for your client.)**

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Have you discussed with the patient whether they would like to continue with the same Mental Health Professional?     Yes     No

If the patient requests a change of Mental Health Professional, what is the identified reason?

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