

**Gold Coast Primary Health Network**

**Psychological Services Program**

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

**Perinatal Program (until one year after childbirth) – PROVISIONAL REFERRAL**

Gold Coast Primary Health Network (GCPHN) can provide expecting and new mums experiencing perinatal depression, access to the Psychological Services Program with an approved Psychological Services Mental Health Professional. This Program is made available through funding from the Psychological Services Program.

The Psychological Services Program provides short term psychological interventions for people with moderate mental disorders who are unable to access other mental health services.

The Perinatal Program is free and offers individual therapy sessions and where necessary, a group therapy program with an approved Psychological Services Mental Health Professional.

**Eligibility Criteria**

Eligible Psychological Services Program clients will have perinatal depression and/or anxiety, moderate in severity, and can benefit from short term psychological intervention.

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

**How to access the Psychological Services Program**

To simplify the referral process and enable timely access to services, provisional referrals into the Psychological Services Program can be **made directly by a Gold Coast University Hospital or Robina Hosptial social worker, midwife or maternal and child health nurse**. This referral form is completed by the social worker, midwife or maternal and child health nurse after determining the client’s eligibility for the program.

This form is then emailed to PCCS at GCTX@pccs.org.au or faxed to **07 3186 4099**.

**Important - As the client is referred by provisional referral by a midwife or maternal or child health nurse, the client must visit their regular General Practitioner (GP) within 2 weeks of referral, to have a Psychological Services Referral and Mental Health Treatment Plan prepared.** Referrals can also be made by the client’s GP.

For further enquiries about the Psychological Services Program, please contact PCCS Intake Team.

Phone: (07) 3186 4099. 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 the client is suffering from or at risk of Perinatal Depression.

2. Confirm client holds a current health care or pension card, or is experiencing financial disadvantage or hardship (document evidence in ‘*Additional Information’*).

3. Obtain client consent for Psychological Services referral and sharing of information.

4. Complete Psychological Services Perinatal Program Provisional Referral form and email to PCCS at GCTX@pccs.org.au or fax on (07) 3186 4099**.**

5. Advise client they are required to attend an appointment with their regular GP for a Psychological Services Mental Health Referral and a Mental Health Treatment Plan. This needs to occur within the next 2 weeks of referral date.

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 Mental Health Treatment Plan.

7. The Referrer completing this referral must also sign (*see below*).

**Perinatal Program (until one year after childbirth)**

**PROVISIONAL REFERRAL**

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Practitioner completing referral: | | | Date: |
| Discipline of referring Practitioner: 🗌 Social Worker 🗌 Midwife 🗌 Maternal Health Nurse | | | |
| Workplace of referring Practitioner: | | | |
| Phone: | Fax: | Email: | |
| I the above named Practitioner believe this client meets the eligibility criteria for the Psychological Services Program, as set out on page one (1). | | | |
| **Does the client have a preference for gender of Mental Health Professional? 🗌 N 🗌 Y Male / Female (please circle)** | | | |
| **Signature of Practitioner completing the referral:** | | | |

**Client Details:**

|  |  |  |
| --- | --- | --- |
| Client Name: | | D.O.B: |
| Daytime Contact Number | Mobile: | |
| Address: | | |
|  | | Postcode: |
| Health Care/ Pension Card No: Expiry Date: | | |
| As part of your assessment of the patient, do you consider there is financial disadvantage?  🗌 Y 🗌 N | | |
| Baby’s D.O.B:  *(up to 1 year of age to be eligible)* | No. of weeks pregnant: | Baby’s Due Date: |
| **Contact Details of Client’s 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 | |
| What is the highest level of education the client has completed: | 🗌 Primary 🗌 Year 10 🗌 Year 11 🗌 Year 12 🗌 Tertiary | |
| Appointment made with their GP for an Psychological Services Referral and Mental Health Treatment Plan? 🗌 N 🗌 Y Date: | | |
| Additional Information relating to this referral: | | |

|  |  |
| --- | --- |
| **Client Consent:**  I consent to the sharing of information, relevant to my referral and treatment, between Queensland Health, Gold Coast Primary Health Network, PCCS, my GP and the Psychological Services Mental Health Professional allocated my referral.  Any information collected from clients will be stored according to each organisation’s strict privacy and confidentiality policies. | |
| Client’s Signature: | Date: |

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

Secure Fax: 07 3186 4099 Email:GCTX@pccs.org.au Phone: 07 3186 4000