

Hawkesbury-Hills Division of General Practice - Patient Registration Form

Use Tab key or mouse to move through fields -enter responses or "X" into the shaded areas

Does the patient have a GP Mental Health Care Plan in Place? <i>(Note: the one plan can be used for referral to individual and/or group counselling).</i>	Yes		If NO, (please complete)
Under the current Mental Health Care Plan has the patient accessed individual therapy?	Yes		No
If NO, is it planned for the patient to access individual therapy?	Yes		No

To obtain registration details, contact the Division's Mental Health area directly on **(02) 8884 9467**

Group Details:		Patient Registration No.:		
		Group No.:		
		Group commencement date:		
Patient Name:				
Patient D.O.B:		Home Phone:		Mobile:
Gender	Male		Female	
Speak English	very well		well	
			not well	
			none	
Other languages spoken at home	Please specify:			
Aboriginal or Torres Strait Islander	Yes		No	Unknown
Live on their own	Yes		No	Unknown
Low Income Earner	Yes		No	Unknown
Previous Specialist Mental Health Care	Yes		No	Unknown
Highest Education Level	Primary		Up to Yr 10	Yr 11
	Yr 12		Tertiary	
Primary Diagnostic Category (ICD 10)	Alcohol & Drug Use F1		Psychotic F2	Depression F3
	Anxiety F4		Unexplained Somatic F5	Other (specify)
Intervention Requested for patient treatment (more than one can be requested)	Diagnostic Assessment		Psycho Education	Interpersonal Therapy
	Behavioural Interventions		Cognitive Interventions	Relaxation Strategies
				Other (specify)
Psychotropic Medication	Benzodiazepines/anxiolytics		Phenothiazines / tranquilisers	
	Antidepressants (SSRI, TCA, SNRI)		Mood Stabilisers (lithium carbonate, sodium valproate, Carbamazapine)	

Referring General Practitioner Details	Email:
Name:	Practice:
	Phone:

I give my consent for my clinical information to be shared with the Allied Mental Health Provider (Psychologist), the Hawkesbury-Hills Division of General Practice Mental Health Team and my referring GP. I agree to my unidentified information (consisting only of the above data) being used to assist in research.

PATIENT SIGNATURE: _____ **GP SIGNATURE:** _____

 **Please fax with a copy of GP Mental Health Care Plan (item 2710) to 9836 1259**