

SERVICE PROVISION FORM

ACCESS TO ALLIED PSYCHOLOGICAL SERVICES

PSYCHOLOGIST'S NAME: _____ SIGNATURE: REFERRING GP's DETAILS: NAME: _____ DATE OF REFERRAL: / /	PATIENT IDENTIFICATION PATIENT'S FIRST NAME: _____ REFERRAL NO: _____ YEAR OF BIRTH (yyyy): _____ SEX: <input type="checkbox"/> M <input type="checkbox"/> F CARER INVOLVED: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide name: _____																		
PLEASE NOTE AFTER THE 6th VISIT A NEW GP REFERRAL IS REQUIRED.																			
1. WHAT TYPE OF SERVICE WAS PROVIDED? <input type="checkbox"/> Individual	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="6" style="text-align: center;">Date</th> </tr> <tr> <th style="width: 16.6%;">1st</th> <th style="width: 16.6%;">2nd</th> <th style="width: 16.6%;">3rd</th> <th style="width: 16.6%;">4th</th> <th style="width: 16.6%;">5th</th> <th style="width: 16.6%;">6th</th> </tr> </thead> <tbody> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </tbody> </table>	Date						1st	2nd	3rd	4th	5th	6th						
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1st	2nd	3rd	4th	5th	6th														
2. DURATION OF SESSION <input type="checkbox"/> 0 – 30 minutes <input type="checkbox"/> 31 – 45 minutes <input type="checkbox"/> 46 – 60 minutes <input type="checkbox"/> >60 minutes	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="6" style="text-align: center;">Date</th> </tr> <tr> <th style="width: 16.6%;">1st</th> <th style="width: 16.6%;">2nd</th> <th style="width: 16.6%;">3rd</th> <th style="width: 16.6%;">4th</th> <th style="width: 16.6%;">5th</th> <th style="width: 16.6%;">6th</th> </tr> </thead> <tbody> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </tbody> </table>	Date						1st	2nd	3rd	4th	5th	6th						
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3. FOCUSED PSYCHOLOGICAL STRATEGY PROVIDED <input type="checkbox"/> Diagnostic Assessment <input type="checkbox"/> Psycho-education <input type="checkbox"/> Cognitive-Behavioural therapy (CBT) <ul style="list-style-type: none"> <input type="checkbox"/> Behavioural Interventions <input type="checkbox"/> Cognitive Interventions <input type="checkbox"/> Relaxation Strategies <input type="checkbox"/> Skills Training <input type="checkbox"/> Other CBT Interventions (please specify in an attachment) <input type="checkbox"/> Interpersonal Therapy <input type="checkbox"/> Other (Please specify)	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="6" style="text-align: center;">Date</th> </tr> <tr> <th style="width: 16.6%;">1st</th> <th style="width: 16.6%;">2nd</th> <th style="width: 16.6%;">3rd</th> <th style="width: 16.6%;">4th</th> <th style="width: 16.6%;">5th</th> <th style="width: 16.6%;">6th</th> </tr> </thead> <tbody> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </tbody> </table>	Date						1st	2nd	3rd	4th	5th	6th						
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4. It is anticipated that there will be no co payment. MUST BE SUBMITTED TO GPpA WITH FINAL INVOICE: NO GST IS TO BE INCLUDED	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="6" style="text-align: center;">Date</th> </tr> <tr> <th style="width: 16.6%;">1st</th> <th style="width: 16.6%;">2nd</th> <th style="width: 16.6%;">3rd</th> <th style="width: 16.6%;">4th</th> <th style="width: 16.6%;">5th</th> <th style="width: 16.6%;">6th</th> </tr> </thead> <tbody> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </tbody> </table>	Date						1st	2nd	3rd	4th	5th	6th						
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