Jacinta Grima

Clinical Psychologist MACPA MAPS FCCLP

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Confirmation of Referral:

Mental Health Treatment Plan (MHTP) or Better Access to Mental Health Care

PLEASE NOTE: Recent changes to Medicare rules require that the referring GP specify the number of psychology sessions on the referral. Please could you therefore ensure that the referral letter states the number of referred sessions (maximum of 6 per standard Better Access referral).

Dear Referrer,

This fax is to confirm that you have referred the following patient for psychological assessment and treatment with Jacinta Grima (Clinical Psychologist) under the Mental Health Treatment Plan (MHTP) or Better Access to mental health care scheme. Please tick the appropriate box and fax as shown below. *Please be aware that a patient can see me without a MHTP/Better Access referral but may not be able to obtain a rebate without a valid referral letter and confirmation of the MHTP/Better Access scheme being completed.* Jacinta Grima (Clinical Psychologist, Provider Number: 5050162B)

Patient Name:	
DOB:	
Address:	
Phone Number:	

◯ **GP:** I am writing to refer the above client. I have completed a GP MHTP and appropriate MHTP Medicare item numbers. ◯ Yes ◯ No

I am referring for (please specify): ◯ 6 sessions under the MHTP or _____ number of sessions

◯ **Psychiatrist/Paediatrician:** I am writing to refer the above client. I have completed an assessment and management plan and/or consultation and appropriate Medicare item numbers ◯ Yes ◯ No

I am referring for (please specify): ◯ 6 sessions under the MHTP or _____ number of sessions

Diagnosis:

◯ Anxiety or Depression (please circle as appropriate)

◯ Behavioural issues or suspected ADHD

◯ Other *(Please write brief details below about the presenting problem. Please be aware if you have ticked 'other' the patient may not be able access a rebate under the MHTP/Better Access Scheme*

_____

Client Medications: _____

Referrer Name: _____ Provider Number: _____

Practice Address: _____

Phone Number: _____ Fax Number: _____

Signature: _____ Date: _____

Please include a copy of the Mental Health Treatment Plan and/or any other documentation as appropriate.

Thank you.