Report to referring GP

Client | Date | Session no.

1. Client and referral details

Client, date of birth, referring GP, date of the referral and of the mental health treatment plan.

2. Reason for referral

The concerns in the referral and in the client's own words.

3. Assessment

Findings, outcome measures with scores, risk.

4. Treatment provided

Number and dates of sessions, approach, main interventions.

5. Progress

What changed and what the client is still working on.

6. Recommendations

Further sessions, review of the plan, other referrals.

> A working template, **not an official Medicare form**. Check the current Better Access guidance before sending.

Report to referring GP: filled example

Client Anna, 34 (fictional) | Date 12/11 | Session no. 6

1. Client and referral details

Anna, 34. Referred by her GP in October under a **mental health treatment plan**.

2. Reason for referral

Work-related anxiety and short sleep. **"They'll fire me for a single mistake."**

3. Assessment

K10 28 at intake, 21 at session 6. Repeated checking keeps the anxiety going. No risk of harm identified.

4. Treatment provided

Six sessions, weekly from October. CBT: thought records, psychoeducation on the checking cycle, behavioural experiments.

5. Progress

Checks reports once instead of five times. Sleep still about 6 hours.

6. Recommendations

Four more sessions to consolidate gains. Suggest a GP review of sleep.

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