FM390 TAILORED THERAPY REFERRAL FORM

Overview:
The Tailored Therapy Day Patient Program is designed to facilitate a person’s transition from inpatient treatment back to the community. The Tailored Therapy Day Patient Program provides psychoeducational groups, behavioral activation structure and engagement in programs designed to assist in recovery and wellness.

The program is time limited. Attendance is generally recommended up to three (3) times per week for this short term intervention. For patients receiving TMS treatment as part of the program, this is likely to be 5 days per week (Monday to Friday).

A psychiatrist’s referral is needed to initiate involvement in the program. Most major Health Fund Providers cover attendance with specific time constraints.

Date Referral Made:

Patient Name:

Gender: Male ☐ Female ☐ Date of Birth:

Patient Address:

Phone No: (Home) (Mobile) (Work)

Private Health Insurance Fund: Membership Number:

Reason for Referral: (How can TT outpatient program assist in patient’s goals? How is the program beneficial to patient? Will skills training assist in short term management of psychiatric illness?)

Will TMS form a component of the TT Care Plan? YES / NO

Diagnosis:

Risk Factors/Alerts: (self harm, aggression, other):

ENTRANCE CRITERIA.

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>RATING</th>
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</thead>
<tbody>
<tr>
<td>1. The patient is able to engage/tolerate 5 hours of group attendance</td>
<td>YES / NO</td>
</tr>
<tr>
<td>2. The patient gives consent to participate in programs (see page 2)</td>
<td>YES / NO</td>
</tr>
<tr>
<td>3. The patient agrees to adhere to group rules (see page 2)</td>
<td>YES / NO</td>
</tr>
<tr>
<td>4. The patient is able to identify needs/goals from TT attendance</td>
<td>YES / NO</td>
</tr>
<tr>
<td>5. For TMS, the patient has been accepted to receive TMS by a TMS psychiatrist</td>
<td>YES / NO</td>
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EXCLUSION CRITERIA

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>RATING</th>
</tr>
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<tr>
<td>1. The patient is acutely unwell or assessed as being high risk and requiring a safe environment with a high level of clinical supervision and monitoring at the time.</td>
<td>YES / NO</td>
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</tbody>
</table>

Psychiatrist Name: ____________________________ Signature: ____________________________

Last Reviewed April 2016  For Review April 2020
TAILORED THERAPY GROUP RULES

- Be respectful of other people in the group
- Please be mindful of the start times of each session you are attending
- Please ensure that your mobile is on silent/vibrate during the group
- Please remember that the group is about discussion that benefits everyone – rather than an opportunity to focus on just one person’s difficulties
- Please maintain confidentiality about any personal information you learn about other group members during the course of the group
- If you are uncomfortable at any time you may leave, the co-facilitator will check in with you at the time.

PATIENT CONSENT FORM

I (print name) ________________________________________________
or _______________________________________.(guardian/responsible person)
as a patient of Dr ____________________________________________

I consent / do not consent (please circle) to participate in the Toowong Private Hospital – Tailored Therapy Program.

I agree that whilst on the Program:

- I will observe the advice of my Psychiatrist
- I will observe the Tailored Therapy Program’s Group Rules
- I will observe the Hospital policies published in Patients Rights and Responsibilities to which I will be taken to have agreed unless I promptly notify the Director of Clinical Services otherwise
- I will pay the Hospital for its services
- I have indicated my consent to use information on the Consent to Use Information Form
- I understand that I am required to participate in the program for the minimum hours required by my health fund.

Signature: ________________________________ Date: _________________

Patient Name

Office Use Only:

Date referral received: ________________________________

Health Insurance Fund Check: YES □ NO □ Consent: YES □ NO □

Financial to start on TT: YES □ NO □ TT Case manager assigned: YES □ NO □

Any Excess stipulations: YES □ NO □ Psychiatrist notified of outcome: YES □ NO □

Office Use Section Completed By:

Name: ____________________________________ Signature: _____________________________