# FINAL REPORT

Please send this two page report **to the referring GP within 7 days of** conclusion of the agreed sessions

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| --- | --- | --- | --- |
| PTS Referral Code: |  | Referring GP: |  |
| Patient Name: |  | No of sessions (max. 5) |  |
| Date of Birth: |  | Date of first session |  |
|  |  | Date of last session |  |
| **Initial assessment findings (incl. any outcome tools used):** |
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| **Summary of progress throughout the sessions:** |
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| **Any ongoing issues:** |
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| **Any other relevant information:** |
|  |
|  |
| **Suggestions for further management:** |
|  |
|  |
| **PTS Provider Name:** |  |  |
| **Signature:** |  | **Date:** |  |  |
| **Practice Name:** |  | **Ph:** |  |  |
|  |  |

***Please return this to the referring GP, and retain a copy for your records.***

Any queries regarding the PTS program should be directed to

Nepean-Blue Mountains Primary Health Network – PTS Manager on 02 4708 8139