

## REFERRAL FORM

Referral Date: \_\_\_\_\_

### PATIENT DETAILS

Full Name: \_\_\_\_\_

D.O.B.: \_\_\_\_\_

Sex: M / F

Address: \_\_\_\_\_

State: \_\_\_\_\_

Postcode: \_\_\_\_\_

Home Number: \_\_\_\_\_

Mobile Number: \_\_\_\_\_

Medicare Card: \_\_\_\_\_

Ref: \_\_\_\_\_ Expiry: \_\_\_\_\_

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### REFERRAL INFORMATION

Primary Diagnosis: \_\_\_\_\_

Reason for Referral (please also attach the patient's detailed Mental Health Care Plan):  
\_\_\_\_\_  
\_\_\_\_\_

Preferred Psychologist (if applicable): \_\_\_\_\_

Number of Sessions Required: \_\_\_\_\_

Current Risk Factors:

Suicide Risk \_\_\_\_\_

Forensic History \_\_\_\_\_

Deliberate Self Harm \_\_\_\_\_

History of Aggression \_\_\_\_\_

Alcohol and/or Drug Misuse \_\_\_\_\_

Other (please specify) \_\_\_\_\_

Current Medications and Dosages:  
\_\_\_\_\_  
\_\_\_\_\_

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### REFERRER DETAILS

Referrer Name: \_\_\_\_\_

Provider Number: \_\_\_\_\_

Position: \_\_\_\_\_

Organisation: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Signature: \_\_\_\_\_

### or REFERRER STAMP

Signature: \_\_\_\_\_