Client Referral Form

Date of referral	

Client Details

Name	
DOB	
Address	
Email	
Phone (Landline)	
Phone (Mobile)	
Medicare Details	Medicare Number: Individual number on card:
DVA details (if applicable)	Type of card: Gold card White card
NDIS (if applicable)	Participant Plan Number: ______________________ ❑ Self-managed ❑ Plan managed Plan manager: ______________ Support Coordinator:_______________________

Referrer details

Name	
Role	
Organisation	
Email	
Phone (Landline)	
Phone (Mobile)	

The Health Psychology Clinic

Service Requested:

- ❑ Individual therapy
- ❑ Couple / family therapy
- ❑ Grief / bereavement counselling
- ❑ Assessment

Presenting Problem

Relevant Medical/Past Psychiatric History & Medications

Other relevant information (e.g risk issues, relevant social Hx)

Treatment Team

General Practitioner	Name: Practice Name:	 Contact number:
Medical Specialist	Name: Practice Name/Location:	Specialist Type: Contact number:
Other relevant health professionals	Name: Practice Name/Location:	Specialist Type:

Proposed funding Source

- ❑ Fee with Medicare rebate
- ❑ Fee with private health insurance rebate
- ❑ Self-funded
- ❑ DVA
- ❑ NDIS
- ❑ Insurance company: _________________
- ❑ Other: ______________________