

## Referral Form

### Referrer Details

REFERRER IS A:

General Practitioner
  Nurse Practitioner
  Others

NAME:

PRACTICE NAME:

PRACTICE EMAIL/FAX : (PREFERRED WAY OF COMMUNICATION):

ADDRESS:

POSTCODE:

PHONE:

PROVIDER NO:

REFERRAL:

### Referrer Details

FIRST NAME:

SURNAME:

DATE OF BIRTH:

ADDRESS:

POSTCODE :

PHONE :

EMAIL (PREFERRED):

MEDICARE CARD (MEDICARE CARD & REF NO.):

NEXT OF KIN, CONTACT NO. AND NAME:

### REASON FOR REFERRAL:

- PSYCHIATRIC ASSESSMENT UNDER 291
- PSYCHIATRIST APPOINTMENT FOR ONGOING CARE (IF ACCEPTED).
- PATIENT/ NON-MEDICARE CARD HOLDER
- REVIEW APPOINTMENT FOR EXISTING PATIENT (MBS 293 OR OTHER RELEVANT ITEM NUMBER)
- PSYCHOLOGIST APPOINTMENT

### DETAILS FOR REFERRAL:

**PAST PSYCHIATRIC HISTORY (INCLUDING HOSPITAL ADMISSIONS):**

**MEDICATIONS:**

**RISK CONCERNS:**

**Please send any additional supportive documents along with this letter**

**\*PLEASE ADVISE YOUR PATIENTS TO CALL US IF THEY HAVE NOT HEARD FROM US WITHIN 5 BUSINESS DAYS OF SENDING THE REFERRAL**