MyPsychologyCoach

041 456 1010
psychologist@mypsychologycoach.com.au
www.mypsychologycoach.com.au

Optimise health, well-being, function and performance in work, life and relationships.

REFERRAL FORM

REFERRAL

Referrer Name : _____

Type of the Referral:

☐ Company / Practice

Name : _____ **Phone :** _____

E-mail: **:** _____

☐ Medical / Healthcare practitioner

Name : _____ **Phone :** _____

E-mail: **:** _____

Medicare Provider Number : _____
(If applicable)

☐ Other Professional

Name : _____ **Phone :** _____

E-mail: **:** _____

Occupation : _____

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REFERRAL FORM

CLIENT

Full Name : _____ **Date Of Birth** : ____ / ____ / ____

Sex : ☐ Male ☐ Female

Address : _____

Phone Number : _____ **E-Mail** : _____

Status : ☐ Single ☐ Married ☐ Separated / Divorced ☐ Other: _____

Employed : ☐ Yes ☐ No **Occupation** : _____

Client aware of referral? : ☐ Yes ☐ No

Support network involved? : ☐ Yes ☐ No

If Yes, **Full Name** : _____ **Employment** : ☐ Yes ☐ No

Relationship to client : _____ **Occupation** : _____

Phone Number : _____ **E-Mail** : _____

*Emergency contact

Relationship to client : _____

Name : _____ **Phone Number** : _____

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REASON FOR REFERRAL (Please check all that apply)

Presenting Problems / Diagnosis

Psychological			
ADHD		Grief	
Alcohol/Substance		OCD	
Anger		PTSD	
Anxiety		Risk assessment	
Bipolar		Sleep	
Depression		Stress	
Eating Disorders			
Other Psychological Problem / Diagnosis, Please Specify:			

Work & Life	
Conflict and Communication	
Job Satisfaction and Career Counselling	
Lifestyle management	
Productivity, Performance or Workplace issue	
Other Work, Life Problem / Diagnosis, Please Specify:	

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REASON FOR REFERRAL (Please check all that apply)

Presenting Problems / Diagnosis

Medical	Description	
Cardiovascular diseases	High blood pressure, heart disease, stroke, peripheral artery disease, deep vein thrombosis, atherosclerosis, congestive heart failure.	
Respiratory diseases	Asthma, chronic obstructive pulmonary disease (COPD), chronic bronchitis.	
Musculoskeletal disorders	Arthritis (rheumatoid, osteoarthritis, psoriatic), gout, lupus, fibromyalgia, chronic back pain, sciatica, carpal tunnel syndrome	
Gastrointestinal diseases	Acid reflux disease, chronic gastritis, ulcerative colitis, Crohn's disease, irritable bowel syndrome (IBS).	
Other conditions	Diabetes, allergies, thyroid disorders, chronic pain, migraines/headaches, skin conditions, menopause, erectile dysfunction, chronic fatigue, substance abuse disorders, sexually transmitted infections (STIs).	
Other Medical Problem / Diagnosis, Please Specify:		

History / Treatment / Medications : _____

Risk assessment : _____

(Suicide risk, Risk to others, Safety / Risk Mitigation / Prevention Plan)

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Recommended therapeutic intervention

☐ **Individual** (CBT, Interpersonal therapy, Positive Psychology, Psycho-education and Skills Training, Motivational Interviewing)

☐ **Couples therapy** ☐ **Veterans** ☐ **Professional / Executive Coaching**

☐ **Mens Psychology** ☐ **Group Seminar**

MEDICARE ELIGIBILITY

Referral

GP Mental Health Treatment Plan : ☐ Yes ☐ No
(Item# 2700 / 2701 / 2715 / 2717)

Psychiatrist assessment & management : ☐ Yes ☐ No
(Item# 291)

Medicare # : _____

Individual reference # : _____ **Valid to :** _____

Signature of Referrer : _____ **Date :** _____

Please complete this form
and email to psychologist@mypsychologycoach.com.au