

Mental Health Services Referral Form

Please complete the Referral form and fax to the Intake Co-ordinator, Mental Health Services.

Upon receipt of this referral, the Intake Co-ordinator will contact your patient to process the referral and inform them of a commencement date and if any payment is required.

Patient Details:

Name: _____ DOB: ___/___/___ Phone: _____
Address: _____ Mobile: _____

Referral Details:

I wish to refer the above patient to the following Group Program (please select one)

- Postnatal Depression Group Program** (Mon & Wed) 9.30am – 3.00pm
 Adult CBT Group Program (Tues & Thurs) 9.30am – 3.00pm

Reason for Referral (please include a brief history):

Medical Conditions / Precautions: _____

Additional clinical information / Special Needs: _____

Doctors Signature: _____ **Date:** / /

Medicare No: pt ref number: _____ Exp ___/___

DVA Number: QX: _____ White Card ___ Gold Card ___

Health Insurance Details:

Fund: _____ Membership No: _____ Table: _____

Self Funded: Patient can obtain an estimate of costs by calling the hospital on 5459 7444.

During the program your patient will be required to have one visit with a Consultant Psychiatrist.

Please indicate if you have a preferred Psychiatrist _____

Or please refer to Dr Burnett Kann ____

Referring Doctor: _____ **Provider No:** _____

Practice Address: _____ **Phone No:** _____

Fax to Intake Co-ordinator on 07 5459 7418