Mid North Coast GP Psychology Service

PATIENT REFERRAL FORM

ALL REFERRALS MUST BE FAXED TO PSYCHOLOGIST

Doctors Stamp Here:

Please indicate how contact is to be made: ☐ **Client to contact Psychologist**
☐ **Psychologist to contact Client**

BOMH registered ☐ yes ☐ no

Patient Details

Surname: First Name: DOB:

Address:

City: Postcode: Home Phone:

Sex: M/F Work Phone:

Referral Date: ____/___/_____ Mobile Phone:

Alternative Contact if Necessary** (**e.g. Carer, next of kin, emergency contact)

Name: Relationship to patient:
Phone:

Reason for Referral:

___

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Please tick ✓ Appropriate Box

Depression	☐	Anxiety disorder (Specify)	☐	Alcohol & Drug Use Disorders	☐
Adjustment disorder	☐	Unexplained somatic complaints	☐	Sleep problems	☐
Eating disorders	☐	Sexual disorders	☐		
Hyperkinetic (attention deficit) disorder	☐	Other (Specify):		Unknown	☐

Current Psychotropic Medication: Dose/regime Date Started Compliance

For which focused strategy is the person being referred (✓ one or more boxes)?

Diagnostic Assessment	☐	Psycho-education	☐	Cognitive-behavioural therapy	☐
Interpersonal Therapy	☐	Other (please specify)	☐		

At Risk? ☐ Yes ☐ No Patient Consent Provided? ☐ Yes ☐ No

Services Used by Patient in the past 6 months: (e.g. community health, mental health, drug and alcohol)