shannon.health@outlook.com
ABN: 96108467642
Phone: 0437112218

Shannon Health

Referral DATE:
Client Name (including Guardian/POA if applicable)
DOB
Phone and Email Contact:
Postal Address
Presenting Issues/Referral Needs:

Specific Assessments required (eg. Cognitive, Diagnostic).

Current Treatment (allied health, medications, other). State frequency, duration and outcomes
Previous Treatment (allied health, medications, other). State frequency, duration and outcomes
Other Medical Concerns

Shannon Health

Referring Medical Practitioner Details
Practitioners Name: Practitioner Address: Phone: Email:
Type of Referral – Please tick one
☐ MHCP – Mental Health Care Plan. Please attach Plan ☐ Private Health Insurance Cover ☐ Self Funded- (non medicare/private health) ☐ Workcover – Claim Number Insuring Agent Insurer Case Manager Name: ☐ NDIS Therapeutic Support– please complete further details below ☐ Other please specify

NDIS Referrals
NDIS Plan Number
Carer Contact where relevant:
Residential Address (or as above):
NDIS Plan Start Date:
NDIS Plan End Date:
NDIS Plan Type: ☐ Self Managed ☐ NDIS Managed
☐ NDIS Managed Plan Managed – Agency Name:
Referrer:
Role of Referrer:
Referrer Contact:
Referrer Email:
Reason for Referral/Client Needs: (additional details)

Shannon Health

Consent Form and Information

Information Collection:

As part of providing a psychological services and/or occupational therapy services, personal information will be requested. This information informs the assessment and treatment being provided. Your informed consent will be obtained before any treatment procedure is initiated, and you may withdraw from treatment at any time without prejudice. You are not obligated to provide any personal information requested; however, withholding information may prevent the therapist from providing you with the services you require. The information retained includes personal contact details, service and billing history and clinical notes and correspondence. However, the Practice limits and restricts the recording of information (including all clinical notes and records) to the bare minimum required to facilitate the provision of the service. We would like to emphasise that your privacy and the information that you provide is protected at all times. All of our psychologists and occupational therapists are registered with the Australian Health Practitioner Regulation Agency (AHPRA) and it is a requirement that all psychologists and occupational therapists follow strict guidelines for professional conduct that is in line with AHPRA and the Australian Psychological Society (APS) Code of Ethics, and Occupational Therapy Australia code of ethics.

Privacy and Security of Client Information

Client files are held in secure physical and electronic storage and are only accessible by your psychologist and practice management. General service, billing and contact information may be accessed by practice management for any reasonable and lawful purpose (e.g. appointment reminders, financial reporting, customer service, etc.) but will never be shared or disclosed to a third party unless required by law.

Confidentiality:

Therapy services are bound by the legal requirements of the National Privacy Principles as set out in the Privacy Amendment (Private Sector) Act 2000. Upon request, you can obtain a copy of these principles, which describe your rights and how your information should be handled. If you have any concerns regarding the collection or storage of your personal information please inform the psychologist

All personal information gathered by the psychologist during the provision of therapy services will remain confidential and secure except when:

1. It is subpoenaed by a court;
2. Failure to disclose the information would place you or another person at risk;

Shannon Health

3. Your prior approval has been obtained to:
    a. Provide a written report to another professional or agency (e.g. teacher);
    b. Discuss the material with another person (e.g. a parent or employer)
4. If you are referred by a GP under a MHTP or CDM you are consenting to the exchange of written/ verbal correspondence regarding your treatment and progress.

Consent to Disclose Information:

Please read this section carefully, and sign below.

Shannon Health is authorised to collect and disclose my personal information, for the purposes of assessment and / or therapy/intervention for which I have been referred from the following people / organisations:

☐ Yes	Treating Therapist (e.g. Physiotherapists, speech pathologist, occupational therapist and/or psychologist)
☐ Yes	Treating Medical providers including specialist (e.g. doctor, paediatricians, psychiatrists, specialist doctors)
☐ Yes	NDIS support coordinators, plan managers or LAC
☐ Yes	Aids and Equipment suppliers/service providers
☐ Yes	Employers, other Job assistance organisations

Client Agreement and Consent

Please print your name and sign below to indicate that you have understood and agree to these terms of service.

I, (PRINT FULL NAME) _____, understand and agree to the above terms of service, policies, fees and procedures in full and acknowledge that my agreement is a fair and reasonable condition of the provision of services for myself and/or my child.

Signed: _____ Date: ____ / ____ / _____