REFERRAL FORM

Psychology Services

Email referrals to intake@abilitypsychologyservices.com and attach relevant documents to referral (e.g. MHCP)

Ability Psychology Services

Referral Information:

Client Name & Date of Birth:

Phone & Email:

Client Address:

Parent/s & Guardian/s (if applicable incl. POA)

Referral For:

☐ **Psychology Appointments**

Preferred Frequency:
- ☐ Weekly
- ☐ Fortnightly
- ☐ Monthly
- ☐ To Be Confirmed

Location:
- ☐ In Clinic
- ☐ Online (Telehealth)

Referral Pathway
- ☐ Mental Health Care Plan (_____ sessions)
- ☐ Private Health Insurance
- ☐ Other (e.g. Private): _____

☐ **Assessment & Report** (Please Specify)

Report Purpose:
- ☐ NDIS Application
- ☐ DSP Application
- ☐ Diagnostic Testing
- ☐ Other: _____

Relevant Information

Diagnosed Conditions: _____

Reason for Referral / Goal of Referral: _____

_____

Current Treatment Team (e.g., GP, Psychiatrist)_____

Brief Summary of Treatment History: _____

Referral Pathway (e.g., NDIS, Private, Mental Health Care Plan, Private Health etc.): _____

Other Relevant Referral Information, Contextual Information &/or Other Questions: _____

_____

Referral Questions & Terms:

	YES	NO
I am aware that I will be contacted to discuss this referral further and have provided my contact information.	☐	☐
I confirm that the Client is aware of and consenting to the referral, and may be contacted.	☐	☐
Are past reports, documentation or other relevant medical history available for review? Please attach to referral, or forward through when otherwise available.	☐	☐
Does the Client have a current treating health team (e.g. Psychiatrist, ACT / PHN engagement or similar?). Please provide relevant details above under "Other Relevant Information".	☐	☐
I am aware that referrals are reviewed by the relevant Intake Team and may not progress, as informed by determinations regarding the suitability and availability of services. Accordingly, I am aware that a referral does not constitute the commencement of support, or an agreement to enter into an episode of care, and thus retain independent duty of care of the client. I am aware that incorrect or insufficient referral information may limit it's progression in the Intake process. Finally, that if a referral cannot be progressed for whatever reason (e.g., if we are unable to contact the referring party and/or client), the referral will be automatically closed with no further action.	☐	☐

Referrer Name:

Signature & Date:

Phone Number & Email: _____

Best Days / Times To Reach You: _____