REFERRAL FORM

NEW CLIENT FORM

Please ensure all sections are completed.

Send completed forms to **Get Psych'd** via: **Fax:** (03) 9960 7575 or **Email:** intake@getpsychd.com.au

Get Psych'd is a private psychology service for youth and young adults. We encourage the referrer to engage the young person and seek their consent to be referred to **Get Psych'd**.

Has the young person given consent to the referral? Yes No

Get Psych'd is not a crisis service or after-hours service. If you require immediate assistance please contact Bendigo Health Mental Health Triage (or your local crisis service) on 1300 363 788 or in an emergency call 000.

YOUNG PERSON'S DETAILS

First Name:

Date of Birth:

D D M M Y Y Y Y

Surname:

Sex:

Male **Female**

Address:

Suburb:

State:

Postcode:

Phone (Mobile):

Phone (Home):

Primary Email:

Preferred contact method/s: **Home Phone** **Mobile Phone** **Email**

Language spoken at home:

Preferred language:

Interpreter needed: **Yes** **No**

Cultural background:

PARENT / CARER / OTHER CONTACT

Name (First and Last):

Relationship:

Phone (Mobile):

Phone (Home):

Email:

Same address as young person: **Yes** *(go to next section)* **No** *(please complete below)*

Address:

Phone: (03) 4416 3221
Fax: (03) 9960 7575
Address: 50-52 Mitchell Street, Bendigo, VIC
Post: PO Box 71, Bendigo, VIC 3552
Email: hello@getpsychd.com.au

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REFERRER DETAILS

Name of Referrer:

Relationship: **Organisation:**

Address:

Phone (Mobile): **Phone (Home):**

Email:

SERVICES AND FUNDING DETAILS

Does the young person see any other services at the moment: If yes, please select the appropriate option/s

Drugs & Alcohol **School Counsellor** **Other Counsellor** **Youth Justice**

Community Services **Adult Mental Health** **Child and Adolescent Mental Health Service (CAMHS)**

Other If other, please specify:

Does the young person have a regular GP? **Yes** *(please complete below)* **No**

Name of GP: **Clinic:**

Will your service continue working with the young person: **Yes** **No**

How does the young person plan to fund accessing Get Psych'd? If known, please select the appropriate option

Full-fee **Private Health** **Medicare** **Third-party funding*** **NDIS***

***If NDIS or Third-party funded, please select if funding is:** **Approved** **Awaiting Approval**

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Get Psych'd youth psychology

REASONS FOR REFERRAL

Main issues:

Pre-existing diagnosis/relevant past history:

What are your expectations of Get Psych'd:

Other comments in regard to referral:

REFERRAL CONTACTS

Is the parent/carer aware of the referral? **Yes** **No** **N/A**

Who should we contact first regarding this referral?

Referrer **Parent/carer/other** **Young person**

If we are unable to contact the young person, can we contact the parent/carer/other contact?

Yes **No** **N/A**

Please inform young person / referral contact they will be contacted via phone.

Date of referral: **Referral completed by:**

D D M M Y Y

Signature:

Please be advised you will receive an automated confirmation of receipt of this referral.
Referrals will be responded to within 3 working days.
If you have not received a confirmation of receipt or had a response from us please call us.

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