AUSTRALIAN PSYCHOLOGY AND SPEECH CLINIC
ASSESS . TREAT . EMPOWER

# Allied Health Service Client Referral Form

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|---|---|
| **DATE OF REFERRAL** | |

| **CLIENT DETAILS** | |
|---|---|
| **FULL NAME** | |
| **HAS THE CLIENT BEEN KNOWN BY A FORMER NAME?** | |
| **DATE OF BIRTH** | |
| **GENDER** | |
| **ADDRESS** | |
| **PHONE NUMBER** | |
| **EMAIL ADDRESS** | |
| **PRIMARY LANGUAGE SPOKEN BY CLIENT** | |
| **IS AN INTERPRETER NEEDED?** | |

| **Primary Contact** | |
|---|---|
| **NAME** | |
| **PHONE NUMBER** | |
| **EMAIL ADDRESS** | |
| **RELATION TO THE CLIENT (IF OTHER THAN CLIENT)** | |

| Client Information | |
|---|---|
| **REASON FOR REFERRAL** | ***Australian Psychology and Speech Clinic does not offer crisis service. If you are in immediate risk of harm, please call 000.*** |
| **CLIENT MEDICAL HISTORY** *Provide brief overview of medical history* | |
| **CLIENT PERSONALITY** *Brief description of the client's personality -any anxiety, mood changes, threatening behaviour* | |
| **MEDICATION** *Please list medications and dosages* | |
| **MEDICAL INFORMATION** | Allergies ☐<br>Anaphylaxis: [Yes/No]<br>Debilitating Conditions: [Specify]<br>DNR (Do Not Resuscitate) Order: [Yes/No]<br>Other: |
| **DIAGNOSTIC INFORMATION** *Does the client have a psychiatric diagnosis? If yes, please provide a detailed description.* | |

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| **PARENTING ORDERS**<br>*Specify any existing parenting orders* | |
| **CUSTODY ORDERS**<br>*Specify any existing custody orders* | |
| **COURT CASE**<br>*Specify any existing legal orders or proceedings* | |
| **PREVIOUS THERAPEUTIC SUPPORT OR ASSESSMENT**<br>*Please specify if the client has had any previous therapeutic support or assessment:* | |
| **OTHER RELEVANT INFORMATION***<br>*(e*.g., Hearing, vision, mobility, substance use) | |

| Services | | |
|---|---|---|
| *Please indicate the allied health service required. If more than one, we will schedule as appropriate.*<br>*Select required services:* | | |
| **PSYCHOLOGICAL ASSESSMENT** | Requesting Psychological Assessment Evaluation. | ☐ |
| **PSYCHOTHERAPY** | Seeking ongoing therapeutic support | ☐ |
| **BEHAVIOUR THERAPY** | Referral for behaviour-focused interventions | ☐ |
| **SPEECH THERAPY** | Requesting speech-related services | ☐ |
| **SPEECH AND LANGUAGE ASSESSMENT** | Seeking assessment for speech and language needs | ☐ |
| **OCCUPATIONAL THERAPY** | Referral for occupational therapy services | ☐ |
| **OCCUPATIONAL THERAPY ASSESSMENT** | Home modification assessments & report at the Client's home | ☐ |
| **OCCUPATIONAL THERAPY ASSESSMENT** | Equipment assessment at the Client's home or at the Clinic | ☐ |
| **OTHER** | Please specify | ☐ |

| Professional Referrer details | |
|---|---|
| **NAME** | |
| **ORGANISATION** | |
| **PHONE** | |
| **RELATIONSHIP TO CLIENT ABOVE** | |

## Therapist Matching Preferences

*We appreciate your commitment to a positive therapeutic experience.*

*Please share your preferences with us.*

*In the event that we are unable to meet your specific preferences, we are dedicated to assisting you by offering recommendations for other local clinics that may better align with your needs.*

| PREFERENCE TYPE | OPTIONS |
|---|---|
| **GENDER PREFERENCE** | Male ☐<br>Female ☐<br>No preference ☐ |
| **LANGUAGE PREFERENCE** | Please specify if you have a preference:<br>☐<br>No Preference ☐ |
| **RELIGIOUS PREFERENCE** | Please specify if you have a preference:<br>☐<br>No preference ☐ |
| **THERAPY LOCATION/CONTEXT**<br>*Please specify your preference for the location of therapy and provide a reason. However, please note that Medicare psychological services do not offer mobile services, and each of our mobile services is judged based on individual cases. We may provide mobile services across our offerings based on specific circumstances.* | At the Clinic ☐<br>In-person (specify preferred location, i.e., home, school, community centre etc)<br>☐<br>Online/telehealth ☐ |

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| **CLINICIAN QUALIFICATION** | Board Certified Professional ☐<br>Student Therapist (for follow-up sessions) ☐<br>No preference ☐ |
| **SPECIFY OTHER PREFERENCES** | Please specify if you have a preference. |

| **Payment/Funding Source:** | | |
|---|---|---|
| **FUNDING SOURCE** | **INSTRUCTIONS** | |
| **MENTAL HEALTH CARE PLAN (MHCP)** | *Please provide your Medicare details during your initial consultation. Our team will assist in processing the Mental Health Care Plan rebate.*<br>***MHCP and Referral Letter required from Medical Practitioner*** | ☐ |
| **OTHER MEDICARE REFERRAL** | *Please contact our team for more details.* | ☐ |
| **NDIS (National Disability Insurance Scheme)** | • *Plan Managed Clients: If your NDIS plan is managed by a plan manager, please provide your plan manager's details during the initial consultation.*<br>• *Self-Managed Clients: If you are self-managed, pay for services directly, and claim reimbursement through your NDIS portal. Keep receipts for submission.*<br>• *NDIA Referrals: Our NDIA referrals are processed through the NDIS provider Western Sydney Community Centre. Please inform our team if you have an existing NDIS plan.* | ☐ |
| **PRIVATE HEALTH FUND** | *If you are using a private health fund, provide the following details:* | ☐ |

| | | |
|---|---|---|
| | • *Health fund name.*<br>• *Membership number.*<br>• *Any specific requirements or documentation needed by your health fund for reimbursement.* | |
| **PRIVATE** | *If you are paying privately, be prepared to discuss our fee structure during the initial consultation. We accept various payment methods for your convenience.* | ☐ |

Thank you for taking the time to complete this form.

Please remember to attach any relevant documents and reports along with this form.

Please return the completed form to admin@auspsychspeechclinic.com.au or mail the completed form to 98-100 Auburn Road, AUBURN NSW 2144.

If you have any questions or need further assistance, please don't hesitate to contact us at admin@auspsychspeechclinic.com.au

You can also reach out to the Australian Psychology and Speech Clinic by calling 0422 953 917.