MINDSIGHT CLINIC

REFERRAL FOR ALLIED HEALTH TREATMENT

REFERRING DOCTOR

Name | Provider Number

Address | Email

Phone (02) | Fax (02)

Signature | Date / / 20

PATIENT DETAILS

Title/First name | Last name | DOB / /

Street Address | Suburb | Postcode

Medicare Number | Ref: | Valid until:

DVA ☐ Workcover ☐

Preferred method of contact (Complete if your patient consents to our reception team contacting them directly to book an appointment)

☐ Mobile | ☐ Email

Alternative contact (Complete if there is someone our reception team can contact if we are unable to reach the patient)

Name | Relationship | Phone number

REFERRAL DETAILS

Treatment required

☐ Initial Allied sessions (6 sessions) – Please attach **Mental Health Treatment Plan** if applicable

☐ Additional Allied Heath sessions (4 sessions) - Please attach **Mental Health Treatment Review** if applicable

☐ Group Therapy: Specify Course

☐ Neuropsychological assessment (please use Neuropsychology referral form via https://mindsightclinic.com.au/neuropsychology)

Clinician

☐ Werner Teichert, Clinical Psychologist (>16 years old)

☐ Ashley Young, Clinical Neuropsychologist & General Psychologist (>16 years old)

Reason for Referral (please include presenting problem, current/past mental health treatment, and any concerns regarding risk to self or others)

Please fax referral to (02) 9157 9022 or email to info@mindsightclinic.com.au