MINDSIGHT CLINIC

REFERRAL FOR CHILD/ADOLESCENT PSYCHIATRY

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:

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

☐ Mobile ☐ Email

Parent/Guardian contact **(If under 16 or requires parental contact for any reason)**

Name | Relationship | Phone number | Email

REFERRAL DETAILS

Reason for referral:

Presenting Problems:

Current Medications:

Relevant Treatment History:

Supporting documents included:

☐ Neuropsychological/educational reports/assessments

☐ Pathology/Imaging results

☐ Correspondence from other professionals e.g. paediatrician, psychiatrist, psychologist, allied health

☐ Other (please specify)

Please email referral and any relevant documents to info@mindsightclinic.com.au or fax to 02 9157 9033