



**REFERRAL FORM GP**

**Date of Referral:** \_\_\_\_\_

**Referring**

**Clinician/Agency:** \_\_\_\_\_

**Medicare Provider No. (GP, Specialists only)** \_\_\_\_\_

**Has a Mental Health Care Plan (MBS Item #2710) been done for this patient? Yes/No**    **Date?** \_\_\_\_\_

**Patient Details:**

Name: \_\_\_\_\_ Medicare No. \_\_\_\_\_

Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

**Reason for Referral (please circle):**

Psycho education / depressive disorder / anxiety / panic attacks / OCD / schizophrenia /  
Stress / trauma / pain / bullying / addiction / aggression / ADHD / behavioral management / school or  
Work / intellectual disability / skill development / relationship problems / family problems / adjustment /  
Career-related issues / supportive counseling / grief & loss / other:

**Goals of therapy**

Assessment / diagnosis / develop treatment plan / provide recommendations and feedback / reduce symptoms  
develop skills / resolve issues / provide focused psychological strategies

Other: \_\_\_\_\_

**Relevant Medical / Psychiatric History:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Urgency of Referral:**                      None /                      Semi-Urgent /                      Urgent

**Suicide Risk:**                              None /                      Mild /                      Moderate /                      High

**Risk to Others:**                            None /                      Mild /                      Moderate /                      High

**Languages available**    Chinese / Cantonese / Greek / English

**Interpreter Required**                      Yes / No                      **Language:** \_\_\_\_\_