

**DEPARTMENT OF CLINICAL AND HEALTH PSYCHOLOGY**

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## AGENCY/HEALTH PROFESSIONAL REFERRAL FORM

REFERRAL INFORMATION	
Referral Date:	
Referring person's name:	
Referring Discipline:	
Agency Name or Contact Base (e.g. ward, unit, department, medical outpatient clinic, organisation):	
Address:	
Phone Number:	E-mail:
Convenient times for department to contact client:	

PATIENT DETAILS			
Family Name:			
Given Name:			
Date of Birth:	Gender: <i>(circle)</i>	Male  Female	Occupation:
Current living situation:			
Age of Infant:	Number of Siblings:	Age of Siblings:	
Address:			
Postcode:	Telephone:	Home:	Work:
Is client aware of referral?		If the client is aware of referral, is it OK to leave a message?	
Yes  No		Yes  No	
UR (unit record Austin Health) if applicable.		Date of last Admission:	
		Discharged: <b>YES/NO</b>	

**REFERRAL DETAILS**

Presenting problem - Information from referrer:

Previous Psychological/Psychiatric History:

Relevant medical information:

ADMINISTRATIVE USE ONLY

Agreed Payment Option

Sliding Scale

Medicare

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