Mental Health Counselling / Psychology / Art Therapy / Chronic Pain
REFERRAL FORM

Fees are charged for this service

Referral Date: _____

Eligibility Criteria – all points below must be met

1. *Experiencing mild to moderate mental health issues*
2. *Currently not in crisis or needing urgent assistance or active case management*
3. *Low risk of aggressive behaviour*
4. *No current family court custody processes*
5. *For specialist ADHD and ASD services please refer elsewhere*
6. *Specific learning disorder – refer to school Psychologist / DSF service*

Personal Details

☐ Child (6yrs+) ☐ Teen (13yrs+) ☐ Adult (18yrs+)

Surname: _____ First Name: _____

Date of Birth: _____ Gender: _____

Parent/Guardian Name *(if under 18)*: _____ Relationship to Person: _____

Address: _____

Suburb: _____ Postcode: _____

Preferred Contact Person: _____

Phone: _____ Email: _____

School: _____

Family Relationships *(complete for child and teen e.g. siblings, family living with the child/teen)*:

_____

Language/s spoken at home: _____ Interpreter Required: ☐ Yes ☐ No

Current Court Order: ☐ Yes ☐ No Description: _____

Emergency Contact Name: _____ Phone: _____

Person Completing Referral Form: _____

Referral Details *please note fees applicable for this service*

Do you have: ☐ Mental Health Care Plan ☐ Pension Card
☐ Private Health Insurance ☐ Health Care Card

NDIS Details

Does the person have an NDIS Plan: ☐ Yes ***(Please include the NDIS Plan to assist with processing of the referral)***
☐ No

How is the NDIS Plan Managed:

☐ **Self-managed**

Person responsible for payment: _____

Phone: _____ Email: _____

Are you able to pay upfront? ☐ Yes ☐ No

☐ **Plan Managed**

Business Name: _____ Contact Name: _____

Phone: _____ Email: _____

☐ **Agency Managed**

☐ **Support Coordinator**

Support Coordinator Name: _____

Phone: _____ Email: _____

Please continue to next page

General Practitioner

General Practitioner Name: _____

GP Practice: _____

Do you give consent for us to liaise with the GP if necessary: ☐ Yes ☐ No

Allied Health Service Required

☐ Mental Health Counselling ☐ Psychology ☐ Art Therapy ☐ Chronic Pain Counselling

Reason for Referral and Other Information

Please tick if you have concerns regarding any of the following:

☐ Anxiety/Depression/Mood Disorder
☐ Trauma Related/PTSD/DV
☐ Grief
☐ Medical Related Stresses/Changes
☐ Sexuality/Identity Difficulties
☐ Family Separation/Stressful Life Events
☐ Chronic Pain
☐ Attachment Support with Parent/Child
☐ Behaviour/Emotional Regulation/Anger
☐ Personal Development
☐ Parenting Strategies
☐ Avoidance/Bullying at school
☐ Work Related Stress
☐ Other Issues:

Please describe the main reason for referral and what you hope to achieve:

Relevant Medical History *(e.g. full-term pregnancy, medication, current and previous diagnosis)***:**

Other service providers involved, including previous therapy *(please provide name)***:**

Please return this completed form, a copy of the NDIS plan and any other relevant documentation to Amity Health via one of the following methods:

Email: query@amityhealth.com.au

Fax: 9842 2798

Amity Health will contact you as soon as possible to discuss your referral.
For more information, please visit our website www.amityhealth.com.au or contact Amity Health on 9842 2797