Grand Pacific Health

Access to Psychological Therapies

Referrer details

Name:	Phone:
Address:	Fax:
Email:	Postcode:

Treating allied health provider (if you are referring to a specific provider)

Name:	Referral date:

Client information

Name:	Date of birth:	Gender:
Parent/carer name (for clients under 14):		Phone:
Postal address:		
Email:		Postcode:
Primary diagnosis (if known):		
Other diagnosis (if known):		
Referred for what strategies (if known):		
Other strategy:		
Receiving psychotropic medication?		

Referral Information

Which program are you referring your client to?

Brief reason for referral:

Please include outcome tool if possible eg DASS 21, SDQ, K-10

If you are a **GP or medical practitioner**, please also attach a **Mental Health Treatment Plan.**

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Consent

Client consent (client to complete) *I understand the nature of this referral and give consent for my information to be shared with Grand Pacific Health. I understand the treatment plans and agree to participate in them.*	Signature: Date:
Referrer consent (referrer to complete) *I have discussed the proposed referral with the client and am satisfied that they understand the reason for the referral.*	Signature: Date:

Please fax the completed form to Grand Pacific Health (GPH) **via secure fax: 02 4226 6489.**

For further information **contact GPH on 4220 7688.**

Office use only

Referrer code:

AHP code:

Unique client identifier:

☐ Suitable for GPH program identified on referral form

☐ If not suitable, specify reason(s):

☐ Suitable for other GPH program, specify:

☐ Additional/alternative treatment options, specify:

Other notes: