

Date of Referral _____

Patient Name _____

Patient DOB _____ Contact Number _____

Address _____

Reason for Referral _____

GOALS FOR TREATMENT (Please tick)

- Improve symptoms & function (home/school)
- Diagnostic clarification
- Address risk
- School attendance
- Other

CONCERNS (Please tick)

- | MOOD SYMPTOMS | ANXIETY SYMPTOMS | BEHAVIOUR DIFFICULTIES |
|---|--|---|
| <input type="checkbox"/> Sleep | <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Self Injury |
| <input type="checkbox"/> Appetite | <input type="checkbox"/> Excessive Worrying | <input type="checkbox"/> Aggression |
| <input type="checkbox"/> Energy | <input type="checkbox"/> Obsession/Compulsion | <input type="checkbox"/> Disruption/Concentration |
| <input type="checkbox"/> Changes in mood | <input type="checkbox"/> Nightmares/Flashbacks | <input type="checkbox"/> (home/school/work) |
| <input type="checkbox"/> Motivation | <input type="checkbox"/> Social Anxiety | <input type="checkbox"/> Motivation |
| <input type="checkbox"/> Reduced interest & enjoyment | <input type="checkbox"/> School Absence | <input type="checkbox"/> Social/Peer difficulties |
| <input type="checkbox"/> Social withdrawal | | <input type="checkbox"/> Concentration |

- | EATING | DEVELOPMENTAL | FUNCTION | RISKS |
|---|---|----------------------------------|--------------------------------|
| <input type="checkbox"/> Restricting/Binging | <input type="checkbox"/> Speech/Language | <input type="checkbox"/> School | <input type="checkbox"/> Self |
| <input type="checkbox"/> Compensating (purging, exercising, laxative) | <input type="checkbox"/> Intellectual performance | <input type="checkbox"/> Home | <input type="checkbox"/> Other |
| | <input type="checkbox"/> Peer relationships | <input type="checkbox"/> Work | |
| | <input type="checkbox"/> Developmental delay | <input type="checkbox"/> Friends | |

- ADDITIONAL INFORMATION** (Needed for MHCP for Psychologist)
- NUMBER of sessions 6 Individual 6 Group
 4 Individual 4 Group
- DIAGNOSIS (please tick one or more if known)
- Mood Disorder Eating Disorder Gender Dysphoria
 Anxiety Disorder ADHD
- REFERRAL FOR SPECIFIC ASSESSMENTS (may not be covered by Medicare)
- Cognitive (psychometric) ADHD Learning Disorder

REFERRING PRACTITIONER DETAILS (or STAMP)

NAME _____

CLINIC _____

ADDRESS _____

PHONE NUMBER _____ FAX NUMBER _____

PROVIDER NUMBER _____

BOOK APPOINTMENT WITH:

PSYCHIATRIST

- Dr Emma Heffernan (Child/Adolescent/Adult)
- Dr Jasveen Kaur (Child/Adolescent/Adult)
- Dr Megan Richardson (Child/Adolescent)
- Dr Nasim Heidari (Child/Adolescent/Adult)
- Dr Sundar (Child/Adolescent)
- Dr Sonali de Sylva (Child/Adolescent)
- Dr Sabine Woerwag-Mehta (Child/Adolescent/Adult)

PSYCHOLOGIST

- Elizabeth Parr – Clinical Psychologist (Adolescent/Adult)
- Fiona Jamieson- Clinical Psychologist (Child/Adolescent)
- Breanna Kelly- Clinical (Child/Adolescent/Adult)
- Nicole Dorrington (Child/Adolescent/Adult)
- Sonja Kubik (Child/Adolescent)
- Swati Basu (Child/Adolescent/Adult)
- Kathy Kent (Child/Adolescent/Adult)

MENTAL HEALTH SOCIAL WORKER

- Melissa Armstrong (Child/Adolescent/Adult)

DIETITIAN

- Kate Feely (Child/Adolescent/Adult)

OCCUPATIONAL THERAPIST

- Lisa Johnson (Adolescent/Adult)