

COUNSELLING SERVICE REFERRAL

Fax (08) 9621 1532
MMEx wgpnreferrals@mmex.gsmhn.com.au
Phone (08) 9621 1530



OFFICE USE DIS Reference Number:

Counsellor:

Funding:

PATIENT DEMOGRAPHICS

Name: Address:	Preferred Counselling Location: _____
Legal Guardian details (if under 16) Name: Address:	Phone: _____ Date of Birth: ____/____/____ <input type="checkbox"/> Male <input type="checkbox"/> Female

Lives alone: Yes No Unknown

Employment: Full-time Part-time Casual Unemployed

Low income: Yes No Unknown

Ethnicity:

Australian Australian Aboriginal Australian South Sea Islander
 Torres Strait Islander Migrant/Refugee Nationality: _____

Education:

Between Primary and Year 10 Primary or below
 Secondary – Year 10 Secondary – Year 11
 Secondary – Year 12 Tertiary

DIAGNOSIS

ICD-10 Primary Care Diagnostic Categories:

Alcohol & Drug Use Psychotic Disorders Unexplained Somatic
 Depression Anxiety Disorders No Formal Diagnosis
 Grief & Loss Peri-Natal Depression Unknown

Presenting Mental Health issues (include alcohol, drugs and smoking status):

Prior Mental Health Care: Yes No Unknown

Please Specify _____

TREATMENT

Referred for Strategies:

- | | |
|--|--|
| <input type="checkbox"/> Diagnostic Assessment | <input type="checkbox"/> Psycho-education |
| <input type="checkbox"/> Interpersonal Therapy | <input type="checkbox"/> Narrative Therapy |

Cognitive-Behavioural Therapy (CBT):

- | | |
|--|--|
| <input type="checkbox"/> Behavioural Interventions | <input type="checkbox"/> Cognitive Interventions |
| <input type="checkbox"/> Relaxation Strategies | <input type="checkbox"/> Skills Training |

Current Medications:

- | | |
|--|---|
| <input type="checkbox"/> Benzodiazepines and Anxiolytics | <input type="checkbox"/> Antidepressants |
| <input type="checkbox"/> Phenothiazines and Tranquillisers | <input type="checkbox"/> Mood Stabilisers |

Other Medications _____

ADDITIONAL RELEVANT INFORMATION / NOTES

CONSENT

Permission to give and obtain information

I _____ (*patient name*) understand that I give consent to my contact details being referred to Wheatbelt GP Network and that they will contact me by phone or letter.

Patient's Declaration Signature: _____ Date: _____
(Guardian for children under 16)

GP Signature: _____ Date: _____

REFERRING PRACTITIONER

Name:

Phone Number:

Address:

Fax Number:

Email:

Referral Date: / /