Mental Health Referral Form w/out MHTP
Full Fee & Private Health patients

FAX REFERRAL TO 9458-0555

QF-24-MH

FORM

Patient Details					
Referral Date		**DOB**		**Mobile**	
Name					
Address					
Email					
Gender	❑ Male ❑ Female ❑ Other				
Origin	❑ Aboriginal ❑ Torres Strait Islander ❑ Unknown				
Language spoken	❑ English (currently InFocus is unable to provide services to non-English speaking patients)				
Does the patient live alone?	❑ Yes ❑ No ❑ Unknown				
Education Level	❑ Primary ❑ Secondary ❑ Tertiary ❑ Other				
Secondary Contact				**Phone**	

Reason for Referral (please provide detail)

Patient Payment Method (InFocus accepts cash, debit or credit card)			
❑	Full Fee	Registered Psychologist	$120.00 per session
❑	Full Fee	Clinical Psychologist	$160.00 per session
❑	Private Health	Name of private health fund:	

Patient Consent	GP/Referrer Details (COMPLETE OR STAMP)
❑ I consent to receive services through the InFocus Counselling Program. **Patient Signature:**	**Name:** **Practice:** **Phone:** **Fax:**

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ACCREDITED

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