

Referrer Details

Name _____ Provider No. _____
 Contact No. _____ Fax No. _____
 Practice Name & Address _____
 Email _____

Patient Details

Name _____ D.O.B _____
 Parent/Guardian _____ Contact No. _____
 Email _____

Suspected Concerns for Assessment

- Sleep Difficulties / Disorders.....
- Mood / Depression.....
- Anxiety (incl. OCD symptoms).....
- ADHD/ ADD.....
- Learning Difficulties / Dyslexia.....
- Performance Difficulties (Work / Sport).....
- Other (please specify)_____

Query Suitability for Treatment

- Psychotherapy / Psychiatry Services.....
Individual (child, adolescent, adult) couples and families
- TMS (Transcranial Magnetic Stimulation).....
Suitable therapy for Depression or OCD. Therapy duration (on average) 20 - 30 sessions total, 2 x sessions weekly minimum
- Neurofeedback (QEEG-informed).....
Suitable therapy for ADHD, Sleep Problems, Cognitive Performance Problems. Therapy duration (on average) 30 - 40 sessions total, 2 x sessions weekly minimum
- Auditory Training Program.....
Suitable therapy for Dyslexia, Auditory Processing Difficulties, Speech & Language Delay/Difficulties. Minimum 20 hours, sessions held daily, may be integrated with other learning / development programs

Further notes

Please mention any further relevant, current and past health information (incl. medication, major illness, head injuries)

Please select the practitioner you are referring to

Psychologists

- Steven Wickens**
- Hazel Kiratli**
- Zhi Xiang On**

Speech Pathologists

- Benjamin Ady**
- Nicolette Choo**

please attach **Mental Health Care Plan for patient Medicare claiming purposes*

Referrer's Signature

Referral Date