Centre for Clinical Interventions

• Psychotherapy • Research • Training

Referral Form

PATIENT DETAILS

Name (including middle name): ______________________________

DOB: ______________________ Medicare Nº: ______________________

Address: ____

Phone Nº: ______________________ Mobile Nº: ______________________

TREATMENT PROGRAMMES (Tick the programme you are referring for)

- ❒ Mood Management Group (Anxiety/Depression)
- ❒ Social Anxiety Disorder Programme
- ❒ Bipolar Group Programme (adjunctive to psychiatric management)
- ❒ Individual Treatment
- ❒ Eating Disorders Programme
  (Following details required for Eating Disorders referrals)
  Patient height: ________ cm
  Patient weight: ________ kg

REFERRAL INFORMATION

PRIMARY DIAGNOSIS:

NB: ***Please check the inclusion criteria for CCI referrals***

REASON FOR REFERRAL:

CURRENT RISK FACTORS: (Please note any details as relevant)	CURRENT MEDICATIONS AND DOSAGE: (You may wish to attach a printed medication profile)
☐ Suicide risk	
☐ Deliberate self harm	
☐ Alcohol misuse	
☐ Drug misuse	
☐ Forensic history	
☐ History of aggression	

REFERRAL SOURCE

Name/Service: ______________________________

Address: ______________________________

Referral date: ___ / ___ / ___

Phone Nº: ________________ Fax Nº: ________________

Please send all referrals to the Clinic Manager at CCI, 223 James Street, Northbridge WA 6003, **or fax to** (08) 9328 5911. Please call us on (08) 9227 4399 if you have any enquiries.