The Royal Children's Hospital Melbourne

PSYCHOLOGY SERVICE REFERRAL FORM

1st Floor, South East Building
Tel: 9345 5881
Fax: 9345 5544
Email: psychology_dept@rch.org.au

(affix label)

UR NUMBER:……

SURNAME:……

GIVEN NAME(S):……..

DATE OF BIRTH:……..

ADDRESS: ……

……..

PHONE: ……MOBILE:……

Date of Referral:	
Referred by (please print):	
Dept/Agency:	
Telephone/page:	

Integrated Mental Health Program	Integrated Mental Health Program	Private Clinic
☐ **CLINICAL PSYCHOLOGY**	☐ **NEUROPSYCHOLOGY**	☐ **CHILD & FAMILY PSYCHOLOGY CLINIC**
☎Tel: 9345 5780 Fax: 9345 5544 psychology_dept@rch.org.au	☎Tel: 9345 5373 Fax: 9345 5544 psychology_dept@rch.org.au	☎Tel: 9345 5917 Fax: 9345 7915 enquiries.cfpc@rch.org.au

If referring to The Child & Family Psychology Clinic, please complete the following:

- GP Referral – Mental Health Plan Attached: ☐Yes ☐No
- Paediatric/Psychiatry Referral – Item charged to Medicare: : ☐Yes ☐No

Reasons for Referral:

Signature: ……..

Date: ……

Parent/child/adolescent aware of referral?

Parent/Child: ☐Yes ☐No

Adolescent: ☐Yes ☐No

Interpreter required: ☐Yes ☐No

Language:……

Medical condition/other relevant details: