REFERRAL FORM
RCH Mental Health Psychology Service

(affix label)

UR NUMBER:……

SURNAME:……

GIVEN NAME(S):……

DATE OF BIRTH:……

ADDRESS: ……

……

PHONE: ……MOBILE:……

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

Psychology Service ☐ **CLINICAL PSYCHOLOGY** ☎Tel: 9345 5780 Fax: 9345 5544 Psychology.dept@rch.org.au	Psychology Service ☐ **NEUROPSYCHOLOGY** ☎Tel: 9345 5373 Fax: 9345 5544 Psychology.dept@rch.org.au	**Private Clinic** ☐ **CHILD & FAMILY PSYCHOLOGY CLINIC** ☎Tel: 9345 5917 Fax: 9345 6002 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: