Mental Health Counselling / Psychology / Art Therapy / Chronic Pain REFERRAL FORM



*Fees are due for this service

Referral Date:	

Eligibility Criteria - all points below must be met

- 1. Experiencing mild to moderate mental health issues
- 2. Currently not in crisis or needing urgent assistance or active case management
- 3. Low risk of aggressive behaviour
- 4. No current family court custody processes
- 5. For specialist ADHD and ASD services please refer elsewhere
- 6. Specific learning disorder refer to school Psychologist / DSF service

Personal Details		
☐ Child (6yrs+)	□ Teen	□ Adult
Name:		Date of Birth: Gender:
Parent/Guardian Name:		Relationship to Person:
Address:		
0 1 1		Postcode:
Preferred Contact Name:		
School:		
		. siblings, family living with the child/teen):
Person Completing Referral Form:		
Emergency Contact Name:		
Referral Details		
•		- *fees applicable
☐ Private He	ealth Insurance	
NDIS Details		
Does the person have an NDIS Plan:	☐ Yes (Please	include the NDIS Plan to assist with processing of the referral)
	□No	
How is the NDIS Plan Managed:		
□ Self-managed		
Person responsible for payment:		
Phone:	Email:	
Are you able to pay upfront?	Yes □ No)
□ Plan Managed		
Business Name:		Contact Name:
	Email:	•
Phone:	_ LIIIaII.	
Phone: ☐ Agency Managed	_ Liliali	<u> </u>
□ Agency Managed	Linaii.	

General Practitioner		
General Practitioner Name:		
GP Practice:		
Do you give consent for us to liaise with the	e GP if necessary: ☐ Yes ☐ No	
Allied Health Service Required		
☐ Mental Health Counselling ☐ Ps	ychology Art Therapy Chronic Pain Counselling	
Reason for Referral and Other Information	on	
Please tick if you have concerns regarding	any of the following:	
□ Anxiety/Depression/Mood Disorder □ Trauma Related/PTSD/DV □ Grief □ Medical Related Stresses/Changes □ Sexuality/Identity Difficulties □ Family Separation/Stressful Life Events □ Chronic Pain □ Attachment Support with Parent/Child Please describe the main reason for reference.		
Delevent Medical History /s at full town	vo anno no v. no odiontion. O umant on discussione elicensesio):	
Relevant Medical History (e.g. Tuli-term pi	regnancy, medication, current and previous diagnosis):	
Other service providers involved, including previous therapy (please provide name):		

Please return this completed form, a copy of the NDIS plan and any other relevant documentation to Amity Health via one of the following methods:

Post: PO Box 5294, ALBANY WA 6332

Fax: (08) 9842 2798

Email: query@amityhealth.com.au

For more information, please visit our website www.amityhealth.com.au or contact us on 9842 2797