GP Referral Form

(Please complete and attach to Mental Health Treatment Plan / Mental Health Treatment Plan Review)

Client Details				
Client Name				
Client Address				
Client Contact Details	**Mobile Phone Number:**		**Email Address:**	

Referral Details			
Referred to (Counsellor/Psychotherapists Name)		**Referral Date**	
Relevant Clinical Notes			

Referring GP Details			
Referring GP		**Provider No.**	
Practice Name			
Practice Address			
Practice Contact Details	**Mobile / Phone Number:**	**Email Address:**	

Please send this referral form to:

Email: info@thinkshift.com.au

Clinic Phone Number: 0411 576 676

Thank you for the referral