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**Psychologists and Psychiatrists 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** | | | |
|  | | | |

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| --- | --- | --- | --- | --- | --- |
| **Referring Psychologist or Psychiatrist Details** | | | | | |
| **Referring Psychologist / Psychiatrist** |  | | **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**](mailto:info@thinkshift.com.au)

**Clinic Phone Number: 0411 576 676**

**Thank you for the referral**