Please email completed form to carlingford@mindconnectionsshs.com.au or to norwest@mindconnectionsshs.com.au

GP/Nurse Practitioner (NP) / Specialist referral letter for Psychiatrist Assessment

Referral to:

Referrer - GP/NP/Specialist details:

*Name:

*Address:

*e-mail:

*Contact Details:

Please tick a box below

- ☐ I am referring for TMS therapy for treatment resistance
- ☐ I will email additional documents regarding history

Patient details

*Name: DOB:

*Address:

*e-mail:

*Contact Tel or Mobile:

Medicare/DVA Nu:

Work cover/3rd party Insurer if applicable: case number:

Health Fund Name: Number:

Reason for Referral (please tick boxes)

- ☐ 291/ 296 New Assessment
- ☐ 293 Review
- ☐ For TMS therapy
- ☐ ADHD /Autism Assessment
- ☐ Intellectual Disability and care
- ☐ Eating Disorder Assessment
- ☐ Work Cover Third party
- ☐ Other specify

Other Clinical Information

*Signature of the Referee:

*Provider Number:

*Date: **Referral validity 12 months** ☐ **Indefinite** ☐