Referral Form

1. Identifying Client Information

First Name: _____ Middle Name: _____

Last Name: _____ Preferred Name: _____

Date of Birth: _____/_____/_____ Sex Assigned at Birth: _____ Gender: _____

Pronouns: _____Phone: _____ Email: _____

Address: _____

2. Service(s) Required (all Telehealth, ages 16+):

☐ Individual psychology support

☐ Autism assessment

☐ ADHD assessment

☐ Parent/Caregiver support

☐ Other: _____

3. Referral Information

Current Diagnoses: _____

Symptoms / Reason for Referral: _____

_____

_____

_____

Current Medications: _____

_____

_____

Assessment results (e.g. K10 or DASS21) or any other information: _____

_____

4. Has a Medicare Plan been prepared?

- ☐ Yes, a Mental Health Care/Treatment Plan (MHCP/MHTP) - MBS Item 91170 (Telehealth)
- ☐ Yes, a Chronic Condition Management Plan (CCMP) - MBS Item 93000 (Telehealth)
- ☐ Yes, a Complex Neurodevelopmental Assessment Plan (under age 25 - referral from Paediatrician or Psychiatrist ONLY) - MBS Item 93032 (Telehealth)
- ☐ Yes, a Complex Neurodevelopmental Management Plan (under age 25 - referral from Paediatrician or Psychiatrist ONLY) - MBS Item 93035 (Telehealth)
- ☐ No medicare plan. Client will pay privately or use alternative sources of funding (e.g. NDIS)

If MEDICARE:

Please indicate the number of **initial sessions allocated***: ____

OR

If this is a plan review, please indicate the number of **additional sessions allocated****: ____

*The maximum number of initial sessions allocated under a MHTP is 6 and under a CCMP is 5.

**The maximum number of additional sessions under a MHTP is 4. A patient must not have more than 10 MHTP sessions in a year. If you have previously written a MHTP for this patient in the past year (with the possibility of unused allocated sessions), please ask your patient to check on MyMedicare (or ring Medicare) to ascertain the number of remaining sessions that are usable in this calendar year. We wish to avoid the scenario of more sessions allocated than they have available and therefore not being able to claim for attended appointments. Thank you for your consideration.

5. Referrer Details

Name: _____ Organisation: _____

Profession/Speciality: _____

Phone: _____ Email: _____

Relationship to client: _____

Provider Number (if applicable): _____

Referrer Signature: _____

Date: _____/_____/_____

AREA FOR REFERRER STAMP

Upon completion of this form, it can be emailed directly to ruby at ruby@neuronestpsychology.com.au