

Referral Form

Clinical & Consulting Psychology
Accredited Counselling

Fax: 1300 611 129
Scan: info@headwayhealth.com.au
Call (02) 9453 3027

Patient

Name _____

DOB _____

Mobile _____

Email _____

Suburb _____

Please provide support for:

- Cancer / illness / health changes
- Kids / family / loved ones
- Anxiety / stress
- Low mood / fatigue / sleep / pain
- Dealing with treatment / decision making
- Intimacy / body changes / relationships
- Familial cancer / genetic concerns
- POTS / Long COVID / Chronic concerns
- Other concerns? _____

Patient to provide permission

I provide permission for my referrer to communicate in writing / verbally about me with HeadwayHealth regarding information that may benefit my care.

Signed _____

Date _____

We will explain options to access services; those eligible for Psychology services under Medicare, will require a Referral Letter and GP Mental Health Care Plan.

Preferred Contact

- Patient will contact HeadwayHealth
- Please call patient

Referral Urgency

I have advised the patient that HeadwayHealth is not a crisis service and in an emergency they should call 000 or attend their local hospital.

Crisis support is available from the Mental Health Access Line (1800 011 511), Beyond Blue (1300 224 636) or Lifeline (13 11 14).

- Priority follow-up required
- Non-urgent follow-up

Referrer details

Name _____

Position _____

Company _____

Phone _____

Email _____

Date _____

- Please confirm receipt / advise of plan
- Please contact me for further information
- Please send more flyers