REFERRAL FORM

BLACK SWAN HEALTH

Mental Health & Psychology Services
t: 1300 820 398 f: 9242 1584 e: psychology@blackswanhealth.com.au

Date of Referral: ___ / ___ / ___

CLIENT DETAILS

Patient Name:	**DOB:**	**Gender:**
Mobile:	**Email:**	
Address:	**Emergency Contact/Next of Kin** Name: Relationship: Phone:	
Medicare Card Number:	**IRN:**	**Expiry:**
Primary Diagnosis:		

REFERRAL INFORMATION

Please note this section is mandatory. Incomplete fields will delay patient care.

Please select one of the following: ☐ Referral (6 sessions) ☐ Review (4 sessions)		
☐ **Please tick to confirm that the patient's Mental Health Care Plan has been billed.**		
☐ **2700**	☐ **2701**	☐ **2712 GP Mental Health Care Plan Review**
☐ **2715**	☐ **2717**	

GP DETAILS

GP Name:		**Provider Number:**
GP Practice:	**Phone:**	**Address or stamp:**
Email:	**Fax:**	
Please Note: 1) Ensure the MHCP is attached and includes previous history, diagnosis and medications. 2) We are unable to accept referrals without a MHCP signed by the referring GP. 3) We are unable to accept EPC referrals.		
Signature:		