CLINIC REFERRAL FORM

The Psychology Wellness Centre welcomes referrals from healthcare providers or people within the community who wish to refer themselves (or children from 6 yrs.+). Please contact the Centre on 4923 2233 if you would like to check if we are the right service for your needs.

Important: **As a training centre we do not provide services for the following issues -**

Urgent, crisis or emergency services; high risk of suicidality or self-harm or violence to others; medico/legal, worker's compensation; family court; or other legal matters; criminal-related behaviours or concerns; current psychotic behaviours or substance use; issues requiring long term intervention; CQU Staff and CQU students undertaking psychology studies.

CLIENT DETAILS

Name:					
DOB:		Gender:	*(Please specify)*		
Address:					
Postal Address:					
Email:		Mobile:			
Other family members seen here?					
Concession Card Holder:	Yes / No	Type of Card:		Expiry Date:	
CQU Student:	Yes / No	Student Id:		Field of Study:	
Do you identify as any of the following?	☐ Aboriginal	☐ Torres Strait Islander	☐ Other *(please specify)*		

PARENT/GUARDIAN DETAILS IF CLIENT IS UNDER THE AGE OF 18 YEARS

Please include details of both parents/guardians.

Parent/Guardian Name:		Phone Number:	
		Email:	
Parent/Guardian Name:		Phone Number:	
		Email:	

DISCLAIMERS

I, _____ *(Full name of Client or Guardian)* understand and acknowledge the following disclaimers.

- The Psychologists working in the Centre are postgraduate students in Clinical Psychology, holding registration or provisional registration with the Australian Health Practitioner Registration Authority (AHPRA).
- All sessions are recorded for training purposes only. Recorded material will be treated as confidential, reviewed by the Psychologists and then erased.
- The initial Intake appointment must be paid on the day of consultation. The account balance for assessments must be paid in full before Assessment reports can be released from the centre.

Signature: _____ Date: _____

REFERRER DETAILS

Name:		Today's Date:	
Organisation/Agency: *(if applicable)*		Occupation:	
Address:			
Email:			
Telephone:		Facsimile:	
Service Type? (Please tick which service you require).	☐ Cognitive / Learning Assessment ☐ ASD/ADHD Assessment ☐ Therapy ☐ TOGETHER Program (Anxiety - Ages 6 – 17 yrs.) ☐ Other (please specify) _____		
Reason for Referral? *Please provide information about your key concerns so that we can determine how to best meet the needs of the client.*			

Forward Referrals to:

Psychology Wellness Centre
Bldg. 32/Ground 32
Bruce Highway
North Rockhampton Qld. 4700

T | 07 4923 2233
F | 07 4930 6999
E | wellness-admin@cqu.edu.au