CRICOS Provider Code: 00219C | RTO Code: 40939

CQUniversity PSYCHOLOGY WELLNESS CENTRE

CQUniversity AUSTRALIA

BE WHAT YOU WANT TO BE
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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.+).

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

- *Children under the age of 6 years*
- *Urgent, crisis or emergency services*
- *High risk of suicidality or self-harm*
- *Violence to others*
- *Medico/legal*
- *Worker's compensation*
- *Family court or other legal matters*
- *Criminal-related behaviour or concerns*
- *Current psychotic behaviours*
- *Current substance abuse*
- *Issues requiring long-term intervention*

CLIENT DETAILS

Name:			
DOB:		Gender:	
Address:			
Postal Address:			
Email:		Mobile:	

CQU Student/Staff:		Field of Study:	

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:	

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REFERRER DETAILS

Name:		Today's Date:	
Organisation: *(if applicable)*		Occupation:	
Address:			
Email:			
Telephone:		Facsimile:	
Service Type? (Please tick which service you require).	☐ Cognitive / Intellectual ☐ Attention Deficit Hyperactivity Disorder (ADHD) ☐ TOGETHER Program (Anxiety Focused Age 7-13yrs)	☐ Learning Disorder ☐ Autism Spectrum Disorder (ASD) ☐ Therapy	
Reason for Referral? *Please provide information about your key concerns so that we can determine how to best meet the needs of the client.* *i.e. Current behaviours, areas of concern/risk. Current medication and treating health professionals. Previous treatment, any diagnosed conditions.*			

Forward Referrals to:

Psychology Wellness Centre
Bldg. 31/Ground Floor
554-700 Yaamba Road
Norman Gardens Qld. 4701
Ph: 07 4923 2233
Email: wellnesscentre@cqu.edu.au