enhance therapeutics
A better you

EXTERNAL REFERRAL FORM FOR ORGANISATIONS AND SERVICES

Referring service/organisation name: _____

Date: _____

Contact person: _____

Contact Number/s: (H)_____(M)_____

Email: _____

Clients Given name: _____Surname: _____

DOB: _____Age: _____

Address: _____

Phone number/mobile_____

Referral reason:

- Mental health and wellbeing- Anxiety, depression, intrusive thoughts, panic attacks other (please tick)
- Grief and loss
- Trauma
- General counselling

Identify reason for referral:

_____
_____
_____

Any risk identified? Suicidality, self-harm, major significant life event, hospital admission, family history etc. Please provide details:

_____
_____

Mode: (circle) Face to face phone video

Are you a NDIS participant? (Circle) Y / N

If yes- what is your NDIS participant number: _____

Are you NDIA/Plan/self-managed? _____

Please provide details plan managers Full name, phone number, and email address for processing:

_____

Please attach a copy of your NDIS plan and or identified goals. (circle) Y **(this must be attached to proceed)**

I (client full name) _____give consent for this referral to be made to enhance therapeutics and for enhance therapeutics to contact me. I give my consent for them to have a copy of my NDIS plan and or goals that is attached to this referral.

Client's signature: _____

Date: _____Time: _____

Referrer's name: _____Signature: _____

If client is under 16 years old parent or guardian consent is required.

Parent/Guardian name: _____Sign: _____

Date: _____Time: _____

Please note: All referrals are subject to an assessment from enhance therapeutics prior to being accepted as a client.

Please email referral to admin@enhancetherapeutics.com.au