REFERRAL TO FAMILY PLANNING NSW PSYCHOLOGY SERVICE (HUNTER) – fax to 02 4926 2029

family planning nsw
Reproductive & Sexual Health

Client Details

Name: _____

Address: _____

Medicare number: _____

Telephone (M) _____ (H) _____ (W) _____

Referrer Details

Doctor's name: _____

Practice address: _____

Telephone number: _____

Clinical Information

Does the client have a medical condition? ☐ Yes ☐ No

If yes, please specify: _____

Has the client attended psychological therapy in the past? ☐ Yes ☐ No

If yes, please specify: _____

Does the client have a mental health diagnosis? ☐ Yes ☐ No

If yes, please specify: _____

Is the client taking any medication? ☐ Yes ☐ No

If yes, please specify: _____

Please indicate the areas that the client would like support in:

☐ Anxiety	☐ Pregnancy	☐ Social Skills	☐ Depression
☐ Health	☐ Legal Issues	☐ Sexuality	☐ Adjustment
☐ Psychosis	☐ Lifestyle	☐ Identity	☐ Eating Disorders
☐ Grief and Loss	☐ Self-esteem	☐ Personality	☐ Anger
☐ Parenting	☐ Other: _____		

Does the client have a mental healthcare plan? ☐ Yes ☐ No

If yes, please attach to the completed referral form.

Doctor's Signature: _____