Patient details

Surname		**Given name(s)**	
Date of birth		**Gender identity**	
Parent/caregiver name			
Address			
Mobile phone number		**Home phone number**	

Referral details

Diagnosis	
Reason for referral	

Referral information

This patient is being referred under:		
☐ Better Access Scheme	☐ 6 sessions ☐ ___ sessions (maximum of 6)	Medicare item billed: ☐Yes ☐No MHTP attached (GPs only): ☐Yes ☐No
☐ Eating Disorder Scheme	☐ 10 sessions ☐ ___ sessions (maximum of 10)	Medicare item billed: ☐Yes ☐No EDP attached: ☐Yes ☐No
☐ Team Care Arrangement	☐ 5 sessions ☐ ___ sessions (maximum of 5)	Medicare item billed: ☐Yes ☐No TCA attached: ☐Yes ☐No

This referral can be used for:	☐ Individual therapy	☐ Group therapy

Referrer details

Practice name			
Practice address			
Practice phone number		**Practice fax number**	
Referrer name			
Referrer provider number			
Referral date			
Referrer signature			

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