



Curtin Psychology Clinic Referral Form

Client details

First Names:	Surname:	M / F
DOB:	Telephone:	Mobile:
Parent /Guardian:		
Street Address:		
Suburb:	Postcode	
Email:		

Referral for (Please tick)

<input type="checkbox"/> CHILD / ADOLESCENT PSYCHOLOGY CLINIC	
<input type="checkbox"/> Individual Treatment	<input type="checkbox"/> OCD Service
<input type="checkbox"/> Learning /Cognitive Assessment	
Group Programs	
Feelings & Friends	Social Life Skills
<input type="checkbox"/> (5-6 yrs) <input type="checkbox"/> (7 yrs)	<input type="checkbox"/> (10-12 yrs)
Positive Thinking Skills	Worry & Rumination
<input type="checkbox"/> (8-9 yrs)	<input type="checkbox"/> (14-17 yrs)

<input type="checkbox"/> ADULT PSYCHOLOGY CLINIC
<input type="checkbox"/> Individual Treatment
<input type="checkbox"/> OCD Service
Group Programs
<input type="checkbox"/> OCD Group
<input type="checkbox"/> Worry & Rumination Group For Anxiety & Depression
<input type="checkbox"/> Mindfulness Wellness Program

Reason for Referral

Current medications and dose

Exclusion criteria In sending this referral, the referrer acknowledges there is/are no known:

<input checked="" type="checkbox"/> Suicide or self-harm risk	<input checked="" type="checkbox"/> Drug or alcohol abuse/dependence	<input checked="" type="checkbox"/> Forensic history
<input checked="" type="checkbox"/> History of psychosis	<input checked="" type="checkbox"/> Child protection / welfare / legal issues	

Details of Referrer

Date of Referral:	
First Name:	Surname:
Position:	Service:
Street Address:	
Suburb:	Postcode:
Email:	
Telephone:	Fax:
Signature:	

Fax to (08) 9266 3679 or Email curtinclinics404@curtin.edu.au

Contact us on (08) 9266 1717 if you have any enquiries.