HEALTH AND WELLNESS CENTRE

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)

☐ **CHILD / ADOLESCENT PSYCHOLOGY CLINIC**

☐ Individual Treatment ☐ OCD Service

☐ Learning /Cognitive Assessment

Group Programs

Feelings & Friends
☐ (5-6 yrs) ☐ (7 yrs)

Social Life Skills
☐ (10-12 yrs)

Positive Thinking Skills
☐ (8-9 yrs)

Worry & Rumination
☐ (14-17 yrs)

☐ **ADULT PSYCHOLOGY CLINIC**

☐ Individual Treatment

☐ OCD Service

Group Programs

☐ OCD Group

☐ Worry & Rumination Group
For Anxiety & Depression

☐ Mindfulness Wellness Program

Reason for Referral

Current medications and dose

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

☒ Suicide or self-harm risk ☒ Drug or alcohol abuse/dependence ☒ Forensic history

☒ History of psychosis ☒ 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

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