

Referral Form

Name _____ M / F _____ D.O.B _____

Telephone _____ Address _____

Reason for referral: _____ Suburb _____

Pain Management Assessment

Adjustment to Disability Counselling

Anxiety Management

Stress-related Counselling

Other

Comment _____

Doctor _____ Specialist _____

Telephone _____ Telephone _____

Insurer _____ Claim Number _____

Contact _____ Address _____

Telephone _____ Suburb _____

Referrer Name: _____ Signature _____

Please Fax to: (02) 9398 4310 or email details to referral@psychi.com.au Please attach a copy of insurer approval if applicable (i.e. non-insurer referrers for workers compensation and CTP claimants).

Please attach any relevant documentation to the referral.

You will be contacted to discuss requirements in detail prior to an appointment being scheduled.

COST for Assessment and report: **\$845.00 (Incl. GST)**

Insurer Approval: _____ Date: _____