HEALAN CENTRE

General Practitioner Referral Form

REFERRER INFORMATION

Full Name :

Profession:

Address:

Email :

Phone:

Have you directly assessed the patient ? Yes No

Has the parent/ carer consented to this referral? Yes No

CLIENT INFORMATION

Full Name :

Address :

Date of Birth : / /

Email : Primary Phone No:

Gender : Preferred Pronouns:

Medicare No: Ref: Expiry:

Current School: Year: Phone:

PARENT OR CARER DETAILS

Full Name : Primary Phone No:

Email : Relationship to Child:

Full Name : Primary Phone No:

Email : Relationship to Child:

Health or Development Difficulties:

Presenting Mental Health Difficulties:

Detail the initial symptoms, their duration, and frequency. Explain how these issues affect the daily life of the young person, such as in school, at home, or in social settings.

Risk Issues

Do you feel that the child is currently at risk due to their mental health difficulties they experience (e.g) deliberate self harm, suicidal, risk to others **Yes** **No**

Is there a current Safety Plan? If Yes, please describe the details of the safety plan. **Yes** **No**

OTHER AGENCIES OR CARE PROVIDERS

Agency:		**Primary Phone No:**	
Email :		**Last Engagement**	
Agency:		**Primary Phone No:**	
Email :		**Last Engagement**	

THANK YOU FOR SUBMITTING A REFERRAL

Kindly forward the referral details to
info@healancentre.com