

### **Medicare Mental Health Plan Referral Form**

#### **Client Details**

Client Title	<b>*</b>				Client Date of Birth *
Mr	Mrs	Ms	Other		
Client Firs	t Name *			Client Last Name *	
Client Pref	erred First	Name			Client Gender *
Client Hon	ne Phone				Client Mobile Phone *
Client Ema	ail Address	*			
Client Add	ress *				
Suburb				State	Post Code
Emergenc	y Contact N	lame			Emergency Contact
Guardian/	Caregiver N	Name (if a	pplicable)		Guardian/Caregiver Phone
Centrelink Yes	(Job Seeke	er, Disabil	ity Support Pen	nsion, Aged Care Pension) *	

\* indicates a required field

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Referring Docto		*	Referring Doctor Last Name *					
Referring Docto	or			Date of Referral				
Referring Docto	or Phone			Referring Doctor Fax				
Referring Docto	ferring Doctor Email Address							
Referring Docto	r Address							
Suburb				State	Post Code			
Doctor Preferre Email	d Method of Phone	Communica Fax	ation Letter					
Psychological Co	onditions							
Other Medical I	ssues							

#### **File Attachments**

If you are filling in this form manually, please attach all relevant documents for this Private/Medicare form.



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## **Subscriptions** \*

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Yes No

