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GP Referral Form

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| **Patient Details** | | | | | |
| Patient name |  | | | | |
| Date of birth |  | | | | |
| Address |  | | | | |
| Medicare Card No. |  | Ref No. |  | Expiry |  |

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| **Service Details** | | | |
| Please state if the patient has a GPMHTP, shared care plan or a psychiatrist assessment and management plan.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ☐Mental Health Treatment Plan (2710, 2715)  Please indicate # of sessions approved  ☐ Mental Health Treatment Plan Review (2712)  Please indicate # of sessions approved | | | |
| Referred to | Jacqui Zdravkovski  Empower You Counselling | Referral Date |  |
| **Presenting issues/Diagnosis/Medication** | | | |
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| **Referring GP Details** | | | |
| Referring GP name |  | Provider No. |  |
| Practice name/location |  | | |
| Contact details |  | | |

Please send this referral to:

**Email:** [info@empoweryoucounselling.com.au](mailto:info@empoweryoucounselling.com.au)