EQUINOX PSYCHOLOGY

98 WOONGARRA STREET
BUNDABERG QLD 4670

Referral Form Date: _____

To be completed for all NDIS, EAP, Workcover and Private Clients

Please Indicate Referral Type:

☐ Medicare/Private ☐ NDIS ☐ EAP ☐ Workcover ☐ Other: _____

Name:	**Gender Type:** **DOB:**
Address:	
Phone:	**Email:**
Next of Kin (Parent if under 18 years):	
Doctors Name:	**Phone Number:**
GP Practice:	

Medicare/Private Clients

Medicare Number: **Individual Ref. Number:** **Expiry:**

Claimant (Parent if client under 18): **DOB:**

Medicare Ref Number.: **Individual Ref. Number:** **Expiry:**

NDIS

NDIS Goals to be Provided.

NDIS NO.: **Plan Dates:**

Plan-Managed: ☐ Self-Managed ☐ NDIA Managed ☐

Plan Manager Details:

EAP/Workcover:

Employer: _____

Contact Details for Invoicing (e.g. name of insurance company):

Suicide/Self-Harm Risk ☐ **Yes** ☐ **No** **If Yes Please Provide Details:**	**History Suicide/Self-Harm Risk** ☐ **Yes** ☐ **No** **If Yes Please Provide Details:**

Currently Supported by Allied Health, Therapist or Counsellor: ☐ **Yes** ☐ **No** **Please provide details including support type (e.g. OT, Speech, Counsellor) and frequency:**

Reason for Referral (Please include information around any cognitive or communication difficulties):