

Referral for mental health assessment and treatment services

Fax referral form to 1300 867 889 or email to referrals@mmhg.com.au Patient will be contacted within 2 business days of receipt.

Patient details

Title/First name _____ Last name _____ DOB _____

Street Address _____ Suburb _____ Postcode _____

Medicare Number _____ Ref: _____ Valid until: _____

Preferred method of contact

Complete if your patient consents to our Patient Care Team contacting them directly to book an appointment.

Mobile _____ Email _____

Alternative contact

Complete if there is someone our Patient Care Team can contact if we are unable to reach the patient.

Name _____ Relationship _____ Phone number _____

Health fund

Fund: Private / self-funded Department of Veteran Affairs Workcover Health fund: _____

Membership / claim number: _____

Referral information

Reason(s) for referral

Major depressive disorder Generalised anxiety disorder Obsessive compulsive disorder Post-traumatic stress disorder
 Other: _____

Medications and clinical notes

In the last 12 months, has this patient: Trialled 2 or more classes of antidepressants (list under additional information below)

Been admitted for psychiatric condition **or** Is currently admitted at: _____

Additional information - include comorbidities, current medication(s), and previous antidepressants trialled if applicable.

Requesting doctor Psychiatrist GP Other: _____

Name _____

Provider number _____

Practice Address _____

The following is required for us to send you patient reports

Mobile _____

Direct Email (not reception) _____

Doctor's signature _____ **Date** _____

Optional: doctor / clinic stamp