CANNONVALE
F: (07) 4967 6799
P: (07) 4967 6700

MACKAY
F: (07) 4898 2299
P: (07) 4898 2700

TOWNSVILLE
F: (07) 4799 1798
P: (07) 4799 1700

NORTHERN AUSTRALIA PRIMARY HEALTH LIMITED
A healthier future for all Australians

OFFICE HOURS Monday to Friday 8.30am – 4.30pm

Referral Form
Mental Health Under 12 Years

If you consider this referral a high priority please call our office after faxing the referral

Eligibility

This child is 12 years or under Yes ☐ No ☐

This child has attended less than 12 ATAPS sessions in the current calendar year Yes ☐ No ☐

Persons Details

First Name | Surname

DOB | Gender

Address | Postcode

Phone (work) | Phone (home) | Mobile

Indigenous Status | Interpreter Required Yes ☐ No ☐

Medicare Card # | Ref # | Expiry | Health Care Card # | Expiry

Applicable Private Health Insurance? Yes ☐ No ☐

Contacts (Complete relevant field/s)

Can we contact these people if we are unable to contact the referred person to schedule an appointment Yes ☐ No ☐

Next of Kin/ Emergency Contact:

Name | Phone

Address | Postcode

Relationship to person:

Carer Details: (if applicable)

Name | Phone

Referrer Details (if applicable)

Name

Organisation

Address | Postcode

Fax | Provider Number

Referral Information

Reason for Referral

Diagnosis

Allergies

Current Medications (Please attach medications summary)

Relevant medical history/conditions (Please attach health summary)

Does this young person have a legal guardian Yes ☐ No ☐

If Yes provide details:

Is there a Child Safety Order/Involvement: Yes ☐ No ☐

If Yes provide details:

Provide details of any other legal issues: (attach separate sheet if required)

Reason for Referral

☐ Definite *mild to moderate* mental disorder.

☐ Symptoms of an *emerging* mental disorder causing significant dysfunction in everyday life

☐ *At risk of* developing a mental disorder (social-emotional-behavioural)

Currently Prescribed Medication: Yes ☐ No ☐

If YES please provide details:

Consent to referral:
I have discussed this referral with the person and/or their guardian and am satisfied that the person and/or their guardian understands a
able to provide informed consent to this referral

Referrer's signature: _____

Referral Date:

Please attach Child Treatment Plan (CTP), Medication Summary and Health Summary

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