Dr Angela Dixon
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Launceston TAS 7250

Phone: 0456 676 531
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HEALTH PROFESSIONAL REFERRAL FORM

Referrer Details:

Name: ______________________ Provider No: ______________________

Referring Agent:

GP / Paediatrician / Psychiatrist / School Counsellor / Allied Health Professional (please specify) ______________

Phone: ______________ Fax: ______________ Email (optional): ______________

Patient Details:

Name: ______________________ DOB: ______________________

Address: ____

Email: ______________ Mobile: ______________ Other: ______________

Presenting Problem/ Relevant background Information:

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Consent:

[ ] The patient will phone Dr Angela Dixon on 0456 676 531 or will email angela@yourspacepsychology.com.au to make an appointment, or

[ ] The patient would like Dr Angela Dixon to contact him/her on the numbers provided above (if you do not specify, we will contact the patient to be sure he/she is being serviced).

For GPs, Paediatricians and Psychiatrists only:

[ ] I have completed a Mental Health Care Plan and am requesting ______ psychology sessions for this patient

[ ] I have not completed a MHCP because the patient is not appropriate at this time/the patient did not want one/I would like the patient to be assessed by a psychologist first.

Signature: ______________________ Health Professional name: ______________________

Once completed, please email this form to angela@yourspacepsychology.com.au. Alternatively, you are welcome to phone on 0456 676 531.