# MENTAL HEALTH REFERRAL FORM

Eden Private Hospital

Phone: (07) 5472 6472
Fax: (07) 5447 7592

Family Name:

Given Name (s):

Address:

Preferred phone no:

Date of Birth: Sex: ☐ M ☐ F

**GP REFERRAL TO PSYCHIATRIST**

| | |
|---|---|
| Referring Dr's Name: | Primary diagnosis |
| Provider no: | Secondary diagnosis |

Reason for referral:

Current Treatment Plan:

**TICK IF INTERESTED IN DAY PROGRAM**

| Scheduled | | Program | Duration | Comments |
|---|---|---|---|---|
| Two x 3 hour sessions per week | ☐ | **CBT Depression & Anxiety** (Cognitive Behavioral Therapy) | **6 weeks** | Psychoeducation, skills training & skills application |
| One full day per week | ☐ | **Healthy Body Healthy Mind** (Physical health & mental health) | **5 weeks** | Psychology, exercise physiology, occupational therapy & dietetics approach to treatment of mood and anxiety disorders |
| Two x 3 hour sessions per week | ☐ | **Psychological Injury - PTSD** A program for those who have experienced mild to moderate ongoing trauma | **4 weeks** | Skills training, application and psychoeducation approach |
| Two x 3 hour sessions per week | ☐ | **Young at Heart (CBT for over 65 yrs)** | **6 weeks** | Psychoeducation, skills training & application in treatment of mood & anxiety disorders with cognitve decline |
| One full day per week | ☐ | **Acceptance & Commitment Therapy (ACT)** | **6 weeks** | Skills training, application and education approach for mood & anxiety disorders |
| One 3 hour session per week | ☐ | **Addictive Behaviors First Step ( misuse of alcohol, prescription meds, gambling, gaming)** | **12 weeks** | Skills training, application and psychoeducation approach |
| One 3 hour session per week | ☐ | **Successful Sleep - CBT for Insomnia** | **6 weeks** | Skills training, application and psychoeducation approach |

**Some pick up transport options available, please would like contact to discuss: Yes**

**GP Signature:**_____**Date:** _____

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(.) 0800 18/4/2019

## Health Insurance Details

Health Fund : Membership No: Date Joined:

DVA:

☐ Work Cover ☐ QLD ☐ Third Party

Request letter for approval attached: ☐

Insurer:_____Case Manager:

Case Manager Email:_____Approval No:

Additional Information: _____

Comments:

PLEASE RETURN COMPLETED FORM TO EDEN PRIVATE HOSPITAL
Eden.admissions@healthecare.com.au
Fax: (07) 5447 7592

For program enquiries please contact
Program Manager - Deb Hediger PH: 1800333674