



Adelaide Institute for Sleep Health Level 2A Mark Oliphant Building 5 Laffer Drive, Bedford Park SA 5042 https://www.flinders.edu.au/health-medical-research-institute/clinicaltranslation/sleep-health/sleep-health-treatment

## **Psychologist Referral Form**

To arrange appointments for insomnia and circadian management, please email this <u>completed referral form</u> and <u>Mental Health Care Plan</u> to <u>sleephealthtreatment@flinders.edu.au</u>. Our staff will contact your patient with a suitable appointment time. We suggest booking a long consult to provide sufficient time to complete the referral.

## **Patient Details**

First name:				Surname:					
Date of birth:				F	Phone:				
Medicare number:					IRN:				
En	nail address:			1	I				
Address:									
Cli	nical details:								
Re	ferring Physicia	n Details:		GP	Specialist	Psy	ychiatrist* Paediatrician*		
Date:				Provider number:					
Referring doctor:									
Practice name:					1	'			
Email address:				Phone nun		r:			
Address:						I			
*Ur	der the Better Access initiativ	e, a MHCP is not required for	r Psyc	chiatric and Paedia	atric referrals.				
CI	inical Signs/ Syr	nptoms/ History							
	Difficulty falling asleep			Impact on focus, productivity			Circadian rhythm problem		
	Awakenings during the night			Excessive sleepiness			Shift work disorder		
	Inability to return to sleep			Distress regarding sleep			Anxiety		
	Unrefreshing sleep			Obstructive sleep apnoea			Depression		

Length of presenting sleep problem:

Reliance on medication to sleep

Impact on mood, energy, relationships

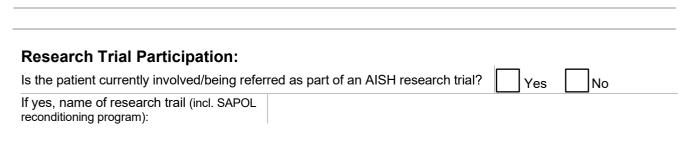
Frequency of sleep problem (days/week):

Trauma

Brief description of presenting issue (e.g., onset, previous treatments, and response to treatments):

**Restless legs** 

Other, please specify:





65 542 596 200, CRICOS No. 00114A

ABN





## **Preferred Psychologist:**

Any	Clin. Psych	ologist	Re	g. Psychologist		Prov. Ps	sychologist						
Dr Gorica Micic	Gorica Micic Ms Claire D			Inbar Mr Greg Gardener			Prof Leon Lack						
Wait times between clinicians vary. We will endeavour to meet requests for preferred clinicians but cannot guarantee availability.													
Please confirm a Physician referral form has been completed       Yes         and accompanies this referral. This a requirement of our services:       Yes													
Preferred Cover:	I												
Medicare Rebates*	Private Co	ver	NDIS		Out-of-pocket								
Number of sessions being referred for via MBS:													
Are any MHCP sessions currently used by another Psychologist?													
* A Mental Health Care Plan MUST accompany this referral for patients to access MBS rebates under the Better Access initiative.													
Other Services/Clinicians involved in patient care:													
Name	Organisation		Profes	Profession		Contact Nu	mber						
Psychiatric diagnoses:													
Diagnosis		Treatme	nt histor	V									
	Provisional     Confirmed												
		Provisional Confirmed											
							Provisional Confirmed						
Medical/Surgical dia	ignoses:	1											
Diagnosis		Treatment history											
	Confirmed												
	Confirm												
							Confirmed						
Current Medications				_	_								
Name	Indica	tions D	lose	Frequency	Pres	cribed by	Duration						
Mental state examination:													
Current Risk Assessment for Suicide and Self Harm:													
Date assessed: / /													
Details:													

the local emergency department. We are not an acute service and cannot respond to immediate high risk.

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