Referral Form

PHONE: 02 7241 5506
EMAIL: office@mindsolution.com.au
WEB: www.mindsolution.com.au
FAX: (02) 7201 5019
ADDRESS: Alexandria | Bankstown | Blacktown
(Telehealth services available)

Please complete the referral form below. Once completed, email the form along with any supporting documents to office@mindsolution.com.au. If you need assistance, please call us on 02 7241 5506.

IMPORTANT: To submit a referral, this must be a CTP or Workers Compensation insurance claim.

What service can we assist you with?

- ◯ Psychology consultation
- ◯ Eye movement desensitisation and reprocessing (EMDR) therapy
- ◯ Psychological functional assessment
- ◯ Occupational therapy (OT) driving assessment
- ◯ Driving rehabilitation program
- ◯ Tinnitus counselling service
- ◯ Other

Have a preferred psychologist or counsellor? (If yes, please specify their name)

Patient Details

Title | First Name | Last Name

Contact Number | Email

DOB | Date of Injury

Suburb | Postcode | State

Reason for referral

Insurer Details

◯ Tick if Referrer

Insurance provider name:

Contact Name | Contact Number

Email | Claim Number

Treating Practitioner Details

◯ Tick if Referrer

Title | Name | Provider No.

Clinic Name | Practitioner Type (e.g. GP, Physio)

Contact Number | Email

Signature **Date**