REFERRAL FORM
DR. TIMOTHY J SHARP & ASSOCIATES
Phone – 02 9231 2522 Fax – 02 9231 2533 email – info@makingchanges.com.au

Rehabilitation Provider

Name: ……………………………………………… Organisation: ………………………………………

Phone: …………………. Fax: ………………….… Mobile: ………………………………………………

Postal address: ……………………………………………………………………………………………………..

Email: ………………………………………………………

Insurer

Contact Person: ……………………………………………… Company: ………………………………………

(please tick) … Rehab. Adviser … Claims Mgr … Referrer

Phone:…………………. Fax: ………………….… Email:. ……………………………………………

Postal address:……………………………………………………………………………………………………

Client's Claim No: ……………………………………

Have you obtained approval from the insurer for an initial assessment? *YES NO
****Please forward a copy to fax: (02) 9231 2533 or email: info@makingchanges.com.au***

General Practitioner

Name: ……………………………………………… Organisation: ………………………………………

Phone:…………………. Fax: ………………….… Email:. ……………………………………………

Postal address:……………………………………………………………………………………………………

Client

Name: Miss / Ms / Mrs / Mr ………………………………………………… D.O.B.: ……………………….

Phone: ……………………… (hm) ……………………… (wk) ……………………………………… (Mobile)

Postal address:……………………………………………………………………………………………………

Reason for referral:…………………………………………………………………………………………

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Initial Assessment for Psychological Treatment and Report Service Required for:

[ ] Pain Management Program
[ ] Stress / Depression Management Program
[ ] Post Traumatic Stress Disorder (PTSD) Program
[ ] Other ……………………………………………………………………………………………………

Will an interpreter be required? (Please circle) NO *YES - Which Language?…………………………..
***If English is their second language please rate their skills:**

- Speaking 0 1 2 3 4 5 (0= Not at all 3= Moderate 5= Excellent)

- Reading 0 1 2 3 4 5 (0= Not at all 3= Moderate 5= Excellent)

- Writing 0 1 2 3 4 5 (0= Not at all 3= Moderate 5= Excellent)

Please send all relevant information to the psychologist. (i.e. Psych/Rehab/Medical reports etc)

Location (please select)

Mona Vale North Ryde CBD Bondi Jn. Liverpool Parramatta

Would you like a copy of our Psychological Services Summary? YES email ☐ /post ☐ **NO**

Office Use Only: Appt. Date …………../…../….. Time………….. Psych …………….. Phoned …….