## Psychological Therapies Review Form



## **PLEASE NOTE**

- \*This form is for review purposes only. If this is the first time you are referring your patient please complete a new referral
- \*This form can be used if a client requires a change in program, support intensity or additional support needs
- \*Any period greater than 3 months between blocks will require a new referral

Review Type	Client Information	
☐ Additional block of 6 sessions	Client full name:	DOB:
☐ Step up – To Suicide Prevention	Gender: ☐Male ☐ Female ☐ Other:	
☐ Step Down – From Suicide Prevention	Street Address:	
Date of review:	Suburb:	Postcode:
Name of GP:	Home Phone:	Mobile:
Practice name:		
Phone:	Is the client currently at-risk of suicide or self-harm?	
Fax:	☐Yes ☐No ☐Unknown	
Additional concerns or comments	Any changes in contributing factors (☑ all that apply)	
	□Chronic disease:	_ □Legal / corrections issues
	□Serious accident / injury	☐Alcohol or drug related problems
	□Grief / loss	$\square$ Gambling problem / other addiction
	□Physical Disability	□Discrimination
	□Intellectual disability	□Trauma
	□Divorce or separation	☐Bullying and/or harassment
	□Sexual assault/abuse	□Child safety interactions
	☐Unable to secure employment	□Other, specify:
	At the completion of this review please fax to (07) 3277-8128.  If you have any questions please contact a member of the Psychological Therapies team on (07) 3717-7006	

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