



Referral Form to Allied Health Professional

PATIENT DETAILS

Full Name:	Date of Birth:	Identity: Female Male Other
Address:		
Home Phone:	Mobile:	
Email:		
Preferred method of contact:		

TYPE OF REFERRAL

<input type="checkbox"/> Mental Health Care Plan	<input type="checkbox"/> Concession or Pension Card Holder
<input type="checkbox"/> Brisbane MIND (ATAPS)	<input type="checkbox"/> Private Health Insurance
<input type="checkbox"/> WorkCover	<input type="checkbox"/> Department of Veteran Affairs (DVA)
<input type="checkbox"/> Better Start for Children with Disability Initiative	<input type="checkbox"/> Helping Children with Autism Program
<input type="checkbox"/> Other:	

REASON FOR REFERRAL

Mental Health & Development

<input type="checkbox"/> Anxiety, Depression	<input type="checkbox"/> Bipolar Disorder	<input type="checkbox"/> ADHD / ASD/ Asperger's
<input type="checkbox"/> Educational / Cognitive Assessment	<input type="checkbox"/> Relationships /Couples	<input type="checkbox"/> Asperger's / Autism Spectrum
<input type="checkbox"/> Parenting Support	<input type="checkbox"/> Bariatric Surgery	<input type="checkbox"/> Weight-related disorders
<input type="checkbox"/> Early Development Intervention	<input type="checkbox"/> Self-Harm/Suicide	<input type="checkbox"/> Substance Addictions
<input type="checkbox"/> School Support/Bullying	<input type="checkbox"/> Geriatric Care	<input type="checkbox"/> Sexuality (all LGBTI matters)
<input type="checkbox"/> Postnatal Depression	<input type="checkbox"/> PTSD & Complex Trauma	<input type="checkbox"/> Foetal Alcohol Syndrome

Behavioural and Developmental Paediatrics

<input type="checkbox"/> ADHD	<input type="checkbox"/> Autism Spectrum Disorder	<input type="checkbox"/> Asperger's Syndrome
<input type="checkbox"/> Learning & Behavioural Concerns	<input type="checkbox"/> Intellectual difficulties	<input type="checkbox"/> Foetal Alcohol Syndrome (FASD)

Neuropsychological Assessment

<input type="checkbox"/> Acquired Brain Injury (ABI)	<input type="checkbox"/> Memory Issues	<input type="checkbox"/> Intellectual Impairment
<input type="checkbox"/> Dementia Assessments	<input type="checkbox"/> Learning Disability	<input type="checkbox"/> Return to work/fitness of duty
<input type="checkbox"/> WorkCover Assessments	<input type="checkbox"/> Insurance Assessments	<input type="checkbox"/> Foetal Alcohol Syndrome

Occupational Therapy

<input type="checkbox"/> Gross & fine Motor Skills	<input type="checkbox"/> Sensory Processing	<input type="checkbox"/> Emotional Regulation
<input type="checkbox"/> Coordination & Movement	<input type="checkbox"/> Medical Driving Assessment	<input type="checkbox"/> Mobility equipment prescription
<input type="checkbox"/> Early development	<input type="checkbox"/> School Readiness	<input type="checkbox"/> Life Skills

Diet & Nutrition

<input type="checkbox"/> Food sensitivity and behaviour	<input type="checkbox"/> Weight control in children	<input type="checkbox"/> Food intolerance
<input type="checkbox"/> Diabetes	<input type="checkbox"/> High cholesterol/blood pressure	<input type="checkbox"/> Gastrointestinal disorders
<input type="checkbox"/> Cardiovascular disease	<input type="checkbox"/> Weight loss	<input type="checkbox"/> Coeliac Disease



Physiotherapy		
<input type="checkbox"/>	All shoulder related injuries	<input type="checkbox"/>
<input type="checkbox"/>	Post-operative shoulder rehab	<input type="checkbox"/>
<input type="checkbox"/>	Rotator cuff tears/tendinopathy	<input type="checkbox"/>
<input type="checkbox"/>	Shoulder strength training	<input type="checkbox"/>
<input type="checkbox"/>	Bursitis	<input type="checkbox"/>
<input type="checkbox"/>	Shoulder impingement	
Speech Pathology		
<input type="checkbox"/>	Speech sound development	<input type="checkbox"/>
<input type="checkbox"/>	Speech, Language or Literacy	<input type="checkbox"/>
<input type="checkbox"/>	Language comprehension & expression	<input type="checkbox"/>
<input type="checkbox"/>	Autism Spectrum Disorders	<input type="checkbox"/>
<input type="checkbox"/>	Childhood apraxia	<input type="checkbox"/>
<input type="checkbox"/>	Social Language	
Other Concerns		
<input type="checkbox"/>	Other:	
Comments:		
PREFERRED CLINICIAN		
<input type="checkbox"/>	Next available	<input type="checkbox"/>
<input type="checkbox"/>	Kelvin Grove	<input type="checkbox"/>
<input type="checkbox"/>	Caboolture	
Psychologist		
<input type="checkbox"/>	Santo Russo (Ed & Dev)	<input type="checkbox"/>
<input type="checkbox"/>	Annette Marriott (Ed & Dev)	<input type="checkbox"/>
<input type="checkbox"/>	Michael Duhig (Ed & Dev)	<input type="checkbox"/>
<input type="checkbox"/>	Nicole Wright	<input type="checkbox"/>
<input type="checkbox"/>	Suzanne Hegarty (Ed & Dev)	<input type="checkbox"/>
<input type="checkbox"/>	Amy Isaacs (Ed & Dev)	<input type="checkbox"/>
<input type="checkbox"/>	Julie Power	<input type="checkbox"/>
<input type="checkbox"/>	Natalie Dzodz	<input type="checkbox"/>
<input type="checkbox"/>	Nikita (Nik) Kotlarov	<input type="checkbox"/>
<input type="checkbox"/>	Tracey Besley	<input type="checkbox"/>
<input type="checkbox"/>	Anita Boettger	<input type="checkbox"/>
<input type="checkbox"/>	Lucy Kennedy	<input type="checkbox"/>
<input type="checkbox"/>	Nicole Morel	<input type="checkbox"/>
<input type="checkbox"/>	Shanling Su (Ed & Dev)	<input type="checkbox"/>
<input type="checkbox"/>		<input type="checkbox"/>
Behavioural and Developmental Paediatrician		
<input type="checkbox"/>	Dr Robert Wishart	
Clinical Psychologist and Clinical Neuropsychologist		
<input type="checkbox"/>	Dr Sarah Pollock	<input type="checkbox"/>
<input type="checkbox"/>	Dr Sasha Hardwick	<input type="checkbox"/>
<input type="checkbox"/>	Rebekah Randall	
Occupational Therapist		
<input type="checkbox"/>	Amanda Smith (& Fritz the therapy dog)	<input type="checkbox"/>
<input type="checkbox"/>	Alicia Rae	<input type="checkbox"/>
<input type="checkbox"/>	Sylvana Spina	
Dietician		
<input type="checkbox"/>	Jocelyn Hunter-Clarke	
Physiotherapist		
<input type="checkbox"/>	Luke Van Every (Luke "The Shoulder Guy")	
Speech Therapist		
<input type="checkbox"/>	Sue Park	
REFERRING DOCTOR (Name, Location and Provider No.)		
Details:		
Date of Referral:		

Thank you for supporting people in need. Please email or fax this form along with other documentation.

The Client will be contacted by our team with appointment availability and details

Phone: (07) 3353 5430
 Email: admin@betterlife.com.au

Fax: (07) 3839 0966
 Web: www.betterlifecentre.com.au

