

REFERRAL FORM



Catherine Knott - Registered Psychologist

| AHPRA Registration: PSY0002709776 | Medicare Provider Number - **1996102L**

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Client Details

Client Name:

Date of Birth:

Address:

Phone:

Email:

Emergency Contact:

Referring Practitioner

Name:

Practice:

Provider Number:

Phone:

Email:

REFERRAL FORM

Referral Type

- Mental Health Treatment Plan (Medicare)
- Private Referral
- Psychological Therapy
- ADHD Assessment
- Autism Screening
- Cognitive Assessment
- Diagnostic Clarification

Presenting Concerns

- Anxiety
- Social Anxiety
- Depression
- Trauma / Complex PTSD
- Stress / Burnout
- Relationship Difficulties
- Parenting Challenges
- Neurodivergence (ADHD / Autism)
- Other:

Relevant History

Mental health history:

Medical history:

Current medications:

Risk Considerations

- None known
- Self-harm risk
- Suicide risk
- Trauma history
- Complex PTSD / trauma-related concerns

Details:

Assessment Question (if applicable)

Please outline the reason for assessment or diagnostic clarification.

Additional Information

Referring Practitioner Signature:

Date:

Client Signature:

Date: