

THERAPY REFERRAL FORM

The Marian Centre's Outpatient Programs

THE MARIAN CENTRE

Growth through choice and understanding

PATIENT DETAILS:

Name: Date of Birth: / / Sex: Male Female

Street Address: Suburb: State: Postal Code:

Health Fund: Membership No.: Referral from: Referral Date: / /

THERAPY PROGRAM:

Mindfulness Based Cognitive Therapy 2-Week Cognitive Behaviour Therapy (day sessions)

Lifestyle Management & Exercise Therapy Program Activity Group

Adolescent Therapy Program Social Anxiety Program

4-Week Cognitive Behaviour Therapy (evening sessions) Enhanced Coping Skills Program

DIAGNOSIS (Please check the box and add comments if necessary):

Major Depressive Disorder Major Anxiety Disorder (please specify)

Bipolar Affective Disorder Psychotic Disorder (please specify)

Substance Use Disorder Disorder (please specify)

Medical Disorder/Condition (please specify)

Others

Comments

PROBLEM AREAS/STRESSORS TO ADDRESS (Please check box and add comments if necessary):

Mood Mx Anger Mx Self-Esteem Occupational

Anxiety/Stress Mx Grief Mx Medical Financial

Guilt Mx Relationship Substance Use Legal

Others

Comments

RISK FACTORS (Please check box and add comments if necessary):

Suicidal ideation/attempt (past/present) Substance misuse (past/present)

Harm to self (past/present) Trauma (past/present)

Harm to others (past/present) Medical illness (past/present)

Others