*Clinic Director and Principal Psychologist*
Dr Alissa Knight
PhD (Psychology)
M.Psych (Clinical)
B.Psych (Hons)
M.Journalism & Mass Communication
B.ED (Junior Primary/Primary)

Specialising in Treatment of Mental Health Conditions
Female Youth (12 – 35 years)

# Referral Form

To be completed by a registered General Practitioner, Psychiatrist, or other relevant Health Professional. Please consider if the patient is eligible for a Mental Health Care Plan or Eating Disorders Treatment Plan through Medicare. Referrer to please complete form to Dr Alissa Knight by Email **info@thecalmingsuite.com.au**

| | |
|---|---|
| Date of Referral: | |

## Client Details

| | | | | |
|---|---|---|---|---|
| Name: | | | Gender: | |
| DOB: | | Client Phone: | | |
| Address: | | | | |
| Email address: | | | | |
| Emergency Contact Name and Phone Number: | | | Phone: | |
| Who is the best person to contact regarding this referral? | ☐ Young person ☐ Parent/guardian ☐ Referrer | | | |
| Does the client identify as an Aboriginal and/or Torres Strait Islander or of a Culturally and Linguistically Diverse background? | ☐ Yes ☐ No<br>☐ Yes ☐ No | | | |
| Is an Interpreter required, if so which language? | | | | |
| If the young person is aged under 16, is the parent or carer aware of the referral? | ☐ Yes ☐ No | | | |

## Referrer Details

| | | | | | |
|---|---|---|---|---|---|
| Name: | | Phone: | | Fax: | |
| Organisation: | | | | | |
| Email address: | | | | | |
| Relationship to young person: | | | | | |

## Consent for Referral

I, _____ [young person], agree to be referred to **Dr Alissa Knight** at **The Calming Suite**

And give my permission for _____ [Referrer's Full Name] to provide/receive written and verbal information to/from **Dr Alissa Knight** for the purpose of facilitating this referral.

*Client signature:* _____ *Date:* _____

What has led to referring the young individual to Dr Alissa Knight? What are the current presenting issues? (you are welcome to attach further information)

Are there any other services currently involved in the young individual's care?

Please indicate if any of the following issues are areas the young individual requires support with:

| | | | |
|---|---|---|---|
| Homeless or at risk of homelessness | ☐ | Trauma | ☐ |
| Pregnancy/young parent | ☐ | Alcohol and drugs | ☐ |
| Family issues | ☐ | Work and Education options | ☐ |
| School/Academic issues | ☐ | Body Image Concerns | ☐ |
| Gender/Sexuality | ☐ | Sleep | ☐ |
| Perfectionism | ☐ | Low Self-Esteem | ☐ |

Please indicate if any of the following Mental Health Conditions you consider the young individual requires support with:

| | | | |
|---|---|---|---|
| Anxiety | ☐ | Bipolar Disorder (Type II) | ☐ |
| Depression | ☐ | Borderline Personality Disorder | ☐ |
| Trauma/PTSD | ☐ | Psychosis | ☐ |
| OCD | ☐ | ASD | ☐ |
| Eating Disorder | ☐ | ADHD | ☐ |
| Intellectual Disability | ☐ | | |

Please Note: mental health assessment and/or therapy for ASD and Intellectual Disabilities are not currently provided by Dr Alissa Knight at The Calming Suite. Please consider specialists in these areas.

## Risk

If you are concerned about this individual's risk to themselves or others, please indicate how:

Tick each of the following options.

Is the young person currently having thoughts of suicide that you are aware of? ☐ Yes ☐ No

Does the young person have a current plan to end their life that you are aware of? ☐ Yes ☐ No

Does the young person have a history of suicide attempts or self-harm that you are aware of? ☐ Yes ☐ No

## GP details

| | | | | | |
|---|---|---|---|---|---|
| Does the client have an existing GP? | | ☐ Yes ☐ No *If yes, please provide details below.* | | | |
| GP Name: | | Phone: | | Fax: | |
| GP practice location/address: | | | | | |
| MHTP | Are you referring this client for a Mental Health Treatment Plan ☐ Yes ☐ No | | | | |

For clients under 16 years (signed consent required by parent/guardian):

Parent/Guardian name: _____

Parent/Guardian signature: _____

Please email completed referral form to Dr Alissa Knight at The Calming Suite on (08) 8471 1010