

# Clinical Psychology Referral Form

**Has the patient consented to the referral and to be contacted by a clinical psychologist?**

Yes  No  (Please note that patients will not be contacted until consent to referral is confirmed).

REFERRING CLINICIAN AND/OR PRIMARY DOCTOR	DATE
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## PATIENT DETAILS

PARTICIPANT NAME (PLEASE PRINT)	DOB
PHONE	EMAIL

## MELANOMA STAGING

In Situ  Stage I  Stage II  Stage III  Stage IV  Family/Carer  Other

PLEASE SPECIFY

## MEDICAL DIAGNOSIS AND TREATMENTS

PLEASE ENTER RELEVANT MEDICAL DETAILS

## REASONS FOR REFERRAL

Anxiety  Stress  Mood Disturbance  Anxiety + Mood  Adjustment/Grief  Not Specified

Other  PLEASE SPECIFY

## EXISTING PSYCHIATRIC/MENTAL HEALTH HISTORY (IF KNOWN)

PLEASE ENTER (PREVIOUS ENGAGEMENT IN PSYCHOLOGICAL/PSYCHIATRIC SERVICES)

## DO YOU HAVE CONCERNS ABOUT THE PATIENT'S CURRENT RISK OF HARM TO SELF/OTHERS?

Yes

No  IF YES, PLEASE GIVE DETAILS

**If your patient is experiencing an emergency or crisis, please contact:** Emergency services on 000, the NSW Mental Health Access Line on 1800 011 511, or Lifeline on 13 11 14. Please note that the Clinical Psychology Service is not an emergency or crisis service.

Interpreter required? NO  YES  Language:

**Please send this form to [psychology@melanoma.org.au](mailto:psychology@melanoma.org.au) or call 02 9911 7285.**

Please attach their most recent medical letter and relevant psychological/psychiatric reports if available.