Crystal Counselling Service

墨尔本专业心理咨询辅导

Tel : 0481 861 038
Email : enquiry@crystalcounselling.com.au
ABN : 66 718 807 319
Website : www.crystalcounselling.com.au

Case Number: (CCS use only)
Date Received: (CCS use only)

Has the patient consented to this referral? **Yes / No**

Referral Source (CCS use only)

GP ☐ Community Centre ☐
School ☐ Funeral Service ☐
Other (please specify) ☐

Name of the Organisation :

Referral Details

Name:

Phone :
Email :
Address :

Patient Details

Name			
Address			
Date of Birth		Gender	
Preferred Language		Ethnicity	

Usually initial contact will be made by telephone: Please indicate whether a message can be left on this number

Preferred contact number		Message Y ☐ N ☐
Alternative contact number		Message Y ☐ N ☐

Additional contact information?

A counsellor will contact the patient to discuss their needs

Presenting Problem (Please tick all that apply and give brief details in the box below)				**Other issues** (Please tick all that apply)	
Depression	☐	Post Traumatic Stress Disorder	☐	Social isolation	☐
Anxiety	☐	Agoraphobia	☐	Debt	☐
Panic	☐	Social Phobias	☐	Employment	☐
Obsessive Compulsive Disorder	☐	Specific Phobias	☐	Relationship	☐
Other:				Housing	☐
Date of onset:				Other (please specify)	

Additional information

Has the patient ever been a risk to **self or others**?	Current medication	Past mental health history
	Physical health	

Any other info. (E.g. Referring to presenting problem, or special needs etc.)