DR ANNA MCKINNON
CLINICAL PSYCHOLOGIST

Dr Anna McKinnon
Level 1/14 Bay Street
Double Bay,
New South Wales, 2028

Health Professional Referral Form

Referrer Details:

Name: ..... Provider No: .....

Referring Agent: GP / Paediatrician / Psychiatrist / School Counsellor / Allied Health Professional (please specify) ……

Phone: ..... Fax: ..... Email(optional):……..……

Patient Details:

Name: ..... DOB: .....
Address: .....
Email: ..... Mobile: ..... Other: .....

Presenting Problem/ Relevant background Information:
.....
.....
.....

Consent:

[ ] The patient will phone Dr Anna McKinnon on 1300 392 548 or will email anna@annamckinnon.com to make an appointment, or
[ ] The patient would like Dr Anna McKinnon to contact him/her on the numbers provided above (if you do not specify, we will contact the patient to be sure he/she is being serviced).

For GPs, Paediatricians and Psychiatrists only:

[ ] I have either completed a Mental Health Care Plan for this patient or equivalent referral (i.e., the patient will be eligible for Medicare rebated sessions)
[ ] I have not completed a MHCP because the patient is not appropriate at this time.
[ ] I have not completed a MHCP because the patient did not want one.
[ ] I have not completed a MHCP because I would like the patient to be assessed by a psychologist first.

Signature: _____

Health Professional name: _____

Once completed, please fax this form to 02 8456 6097. Alternatively, you are welcome to phone us on 1300 392 548 or email us at anna@annamckinnon.com.au.