



Referral Form

Phone: (07) 5220 8793

Fax: (07) 3523 4004

Lvl 2, 60-62 Dalton Drive,
Maroochydore, QLD 4558

www.brainandmindhub.org.au

Please submit your completed Referral Form to us via:
Fax: +61 7 3523 4004, or
Medical Objects: Practice ID #AB4558000ZQ, or
Email: admin@tbmh.org.au
(please send as encrypted files only)

Neuroscience for better mental health

Referring Practitioner

Name _____

Provider number _____

Practice name _____

Phone _____

Fax _____

Signature _____

Date _____

Person seeking support / Client details

First name _____

Surname _____

Preferred name _____

D.O.B _____

Residential address _____

Suburb _____

Postcode _____

Medicare number _____

Ref. _____

Valid until _____

Preferred method of contact Phone _____

Email _____

Alternate contact Name _____

Relationship _____

Phone _____

Reason for referral

Specialist review

Allied health review

Other (please provide details below)

Psychiatry

Transcranial Magnetic Stimulation (TMS)

Psychological therapies

Consideration for Ketamine Treatment

Psychoeducation

Lived Experience Peer Support

Please attach any additional information as extra pages if required