Brain & Mind Hub Sunshine Coast

Neuroscience for better mental health

Referral Form

Submit your completed Referral Form to us via:
(Please send as encrypted files only)

- **Fax:** +61 7 3523 4004, *or*
- **Medical Objects:** Practice ID #AB4558000ZQ, *or*
- **Fax:** admin@tbmh.org.au

brainandmindhub.org.au
Phone: (07) 5220 8793
Fax: (07) 3523 4004
Lvl 2, 60-62 Dalton Drive, Maroochydore, QLD 4558

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
- ☐ Psychiatry
- ☐ Psychological therapies
- ☐ Psychoeducation
- ☑ Allied health review
- ☑ Transcranial Magnetic Stimulation (TMS)
- ☑ Consideration for Ketamine Treatment
- ☐ Lived Experience Peer Support
- ☐ **Other** (please provide details below)

_____

_____

_____

Please ensure that the patient's comprehensive medical history is attached
We are unable to process this referral and progress with treatment without it

☐ **YES** - Medical history attached

Please attach any additional information as extra pages if required