Launceston Therapy Clinic

Launceston Therapy Clinic Self-referral

Name:……Date of Birth ……..

Phone ……. Email address: ……

Support person contact details i.e Parent/school or third party

Phone: ……Email address: ……..

Will a GP Mental Health Care plan be following this referral Yes/No

Do you have a preference to see a specific Psychologist ……
Do you have a preference for a Male or Female Psychologist please circle

Referral Details:

We need information regarding specific areas you need support with to better match you with a clinician. Please tick the following boxes that apply.

◯	Trauma and PTSD	◯	Eating disorders
◯	Anxiety and Panic attacks	◯	Depression
◯	Pain management	◯	Bariatric Surgery
◯	School refusal	◯	Phobias
◯	Addiction	◯	Self harming thoughts and behaviours
◯	Relationship issues	◯	Other

Please include brief, relevant details if appropriate to your care.

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Please email completed form to admin@launcestontherapyclinic.com.au

Your referral will be reviewed at a triage meeting held each week and you will be contacted to discuss the wait time for an appointment.