

# Denis McCarthy

## Clinical Psychologist

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### Referral Form

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Contact Details: \_\_\_\_\_

#### Reason for Referral:

- |   |  |
|---|--|
| <input type="checkbox"/> Depression                       | <input type="checkbox"/> Mood disorder                       |
| <input type="checkbox"/> Anxiety                          | <input type="checkbox"/> OCD                                 |
| <input type="checkbox"/> PTSD and trauma                  | <input type="checkbox"/> Phobias (Fears)                     |
| <input type="checkbox"/> Insomnia, Sleep issues           | <input type="checkbox"/> Irritable bowel disorder            |
| <input type="checkbox"/> Behavioural difficulties         | <input type="checkbox"/> Eating and body image issues        |
| <input type="checkbox"/> ADHD                             | <input type="checkbox"/> Relationships counselling           |
| <input type="checkbox"/> Couples Therapy                  | <input type="checkbox"/> Dispute Mediation                   |
| <input type="checkbox"/> Anger management issues          | <input type="checkbox"/> Grief, bereavement and loss         |
| <input type="checkbox"/> Self esteem and self development | <input type="checkbox"/> Life transition & adjustment issues |
| <input type="checkbox"/> Workplace bullying               | <input type="checkbox"/> Work Stress/ Stress management      |
| <input type="checkbox"/> Workplace/Executive Coaching     | <input type="checkbox"/> Coping with injury or illness       |
| <input type="checkbox"/> Addiction/Substance abuse        | <input type="checkbox"/> Pain Management                     |
| <input type="checkbox"/> MVA or personal injury           | <input type="checkbox"/> Workers Compensation                |
| <input type="checkbox"/> Other _____                      |  |

Comments:

Referring Doctor: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_