Sonia Miller Mental Health NP

Endorsed Nurse Practitioner and Credentialed ACMHN
Australian Counselling Association
NDIS Registered Provider
ABN: 80 670 144 634

Registration/ Referral Form

Strictly Confidential - This service is provided under National Health (Collaborative arrangements for nurse practitioners) Determination 2010 and Drugs, poisons and controlled substances Act 1981, approval under section 14A (1) Nurse Practitioner. Mental Health Care and is bound by the Commonwealth Privacy Act 1988, the Privacy Amendment (Private Sector) Act 2000 the Personally Controlled Electronic Health Records Act 2012

Patient Details **Please tick if self-referred** ☐

Name:

Date of Birth: …./……/……

Address:

Mobile Phone:
Email:

Next of Kin:
Next of Kin Ph/Mb:

Medicare Number:

☐☐☐☐ ☐☐☐ ☐☐☐ - ☐

Expiry date: ……/……

Diagnosis:

Medication/s:

Credit card details: ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ Expiration date: / CVV/CVV2: ☐☐☐
Details are taken by phone or in person for appointment booking confirmation & cancelations:
Cancelation Policy: https://www.mhnpconsulting.com/about_us

Are you eligible for NDIS? **If so please complete below**

	Yes	No
Do you have an NDIS plan?	☐	☐
Are you - Self managed	☐	☐
- Plan Management Provider managed	☐	☐
- NDIA managed	☐	☐
Do you have a Support Coordinator?	☐	☐

Plan Manager and/or Support Coordinator.
Name:

Agency and address:

Contact details:

Medical Practitioner Details

Name: Dr

Practice:

Address:

Phone numbers:
Fax:

Signature:
Provider No.:

Presenting issues: please provide reason for referral, current presenting issues including risk and previous interventions provided (attach relevant assessment summary)

RECORD OF CONSENT

Please indicate who is consenting to referral, collection, use and disclosure of health information in the course of health assessment, therapeutic interventions, and report to assist treatment.

Adult patient ☐ **Child /adolescent patient (mature minor)** ☐ **Child / adolescent parent or guardian** ☐

Please indicate which method/s of transferring health information you consent:
☐ Fax ☐ Email ☐Australia Post ☐ Registered mail (you agreed to pay for the cost) ☐ PCEHR

Patient / Parent or Guardian to Complete

I agree to information about my mental health and wellbeing being collected, used and disclosed to the Mental Health Nurse Practitioner I am referred to, to assist in the management of my health care.

Patient/Parent/Guardian **Name:** **Date:**

Patient/ Parent /Guardian **Signature:**

MHNP Consulting
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