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| Bee’s Tropical Therapeutic Services |
| Referral Form |
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| Client Details |
| Name: |
| DOB and Age: |
| If Under 18, name of parent/carer: |
| Support person and Telephone: |
| Address: |
|  |
| Telephone: |
| Is the client aware of the referral and provided consent? |
| Does the client have a current Mental Health Care Plan? |
| GP Name and Contact: |
| Medicare Number:  Individual Reference Number:  Expiry Date: |
| Referrer Details |
| Name: |
| GP/Agency: |
| Telephone: |
| Provider Number: |
| Reason for Referral |
| Referrer’s Signature: |
| Date: |
|  |
| Please forward completed referral to BTTS via fax: 07 4773 5408 |
| Or email: [BSlade@Bee’sTTS.com.au](mailto:BSlade@Bee’sTTS.com.au) |
| Please note: current wait lists apply |