

Self-Referral Form Massey University Psychology Clinic

Psychology Clinic PN319 Massey University Private Bag 11222 Palmerston North Phone (06) 350 5196

Email to: massey.clinic.pn@massey.ac.nz

Date of Referral	
Client Name	
Date of Birth	
Age and Gender	
Ethnicity	
Contact Address (incl. Postcode)	
Telephone Number(s)	
Parent/Guardian Name(s)	
Parent/Guardian Contact details	
Can we leave messages? Yes/No	
Email Address	
Referred by (Self/GP etc.)	
GP	
Reason for referral	
Do you have a current diagnosis by a health professional?	Yes/No – If Yes please give details.
(Child only) Are there any custody or access issues related to this child?	Yes/No – If yes please specify.
Are you likely to require report for any legal proceedings E.g. court, guardianship?	Yes/No – If yes please specify.
Are there any other services currently involved?	

Have you seen a psychologist previously?	Yes/No - If yes please give brief information on when, for how long, what focused on & what outcome?
Brief outline of current treatment including any ongoing medication.	
Are there any current safety issues: e.g., suicidal – associated with low mood.	Yes/No If yes please call the Mental Health Crisis Team – a 24-hour service on: 0800 653 357
Contact instructions	Please advise if there are any good/bad times of the day for us to call you, and if you would prefer email contact over phone contact.
Any other additional Information?	

What type of service do you need? (Please select any of the following)

- Formal Cognitive Assessment Assess the current situation and / or therapy

Will this be privately funded or funded by an organisation?

- Privately funded
 Funded by an organisation (Please specify) _____

When privately funded our therapy fees are on a sliding scale based on family income. Please indicate which income bracket you would be in.

- Up to \$70,000
 Over \$70,000

Because we are a training clinic, you may be seen by an Intern. An Intern is in their final year of clinical training and supervised by a Senior Psychologist. Please confirm you consent to this.

- Yes No (we may not be able to progress your application)

Please confirm that you are either making this referral for yourself or that the client is happy for this referral to be made.

- Yes No

Referrer's name	
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On receiving the referral, we will reply to acknowledge receipt of this. Then we will get in contact with you within 3 weeks to discuss if we are the most appropriate service to meet your needs.