

CQ Centre for Change

Compassionate support. Practical solutions. Positive change.

GP Referral Form

Please complete the below referral information and email referrals to admin@cqcentreforchange.com. Referrals are acknowledged within 48 hours.



1. PATIENT DETAILS

Full Name: _____ Gender: Female Male Other
Date of Birth: _____ Medicare Number: _____
Address: _____ Medicare Expiry: ____/____/____
Phone: _____ Health Fund (if applicable): _____
Email: _____ Usual GP (if different): _____
Emergency Contact Name: _____ Interpreter Required: Yes No
Emergency Contact Phone: _____ Language: _____
NDIS Participant: Yes No



2. REFERRAL INFORMATION

Reason for Referral: _____
Presenting Concerns / Goals: _____
Relevant Mental Health History: _____
Current Supports / Services Involved: _____
Medications (please list): _____
Risk Concerns (please detail any risk or safety concerns): _____



3. REFERRER DETAILS

GP Name: _____ Referrer Signature: _____
Practice Name: _____ Date: ____/____/____
Provider Number: _____ Preferred Contact Method: Email Phone
Phone: _____ Would you like updates on
Email: _____ progress? (with consent) Yes No



4. SUBMISSION & COMMUNICATION

♥ Please email completed referral forms to admin@cqcentreforchange.com

♥ Referrals are acknowledged within 48 hours.

♥ With patient consent, referrals may be updated regarding engagement and progress.

Get in touch 



0408 736 078

admin@cqcentreforchange.com

www.cqcentreforchange.com



Servicing Rockhampton, Yeppoon and surrounding areas. Home visits may be available on request.