The Hills Clinic

Referral

Patient's Name: _____

Date of Birth: _____

Phone Number: _____

Outpatient Consultation

- ☐ Psychiatrist: _____
- ☐ Psychologist: _____
- ☐ Other: _____

Inpatient Hospital Admission (Kellyville Only)

- ☐ Mood and Anxiety Program
- ☐ Phoenix Program; *rising above addiction*
- ☐ Workcover/MAA
- ☐ General Psychiatric Admissions

Day Patient Group Programs

- ☐ Mood and Anxiety (CBT)
- ☐ Acceptance Commitment Therapy (ACT)
- ☐ Phoenix 10 - addiction recovery
- ☐ Phoenix 6 - addiction relapse prevention
- ☐ Dialectical Behaviour Therapy (DBT)
- ☐ Bipolar
- ☐ Mood and Food
- ☐ Other: _____

Clinical Notes

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☐ KELLYVILLE
15-17 Memorial Ave,
Kellyville, NSW 2155

Hospital
T: 1300 122 144
F: (02) 8883 1834

Medical Centre
T: (02) 8867 0524
F: (02) 8867 0598

☐ CASTLE HILL
26 Hume Ave
Castle Hill, NSW 2154
T: (02) 9899 3618
F: (02) 9899 3617

☐ HORNSBY
45 Palmerston Rd
Hornsby, NSW 2077
T: (02) 9472 4700
F: (02) 9987 4768

Referral Information

Doctor:

Address:

Phone Number:

Provider Number: Date: Doctor's Stamp