THE UNIVERSITY OF ADELAIDE AUSTRALIA
School of Psychology

Centre for Treatment of Anxiety and Depression (C.T.A.D.)
Cognitive-Behaviour Therapy and
Mindfulness & Acceptance-Based Therapies
30 Anderson Street
THEBARTON SA 5031
Ph: 82228100 Fax: 82228101 DX: 465738

Government of South Australia

Incomplete Referrals will not be accepted

Date of Referral: _____ **Completed by:** _____

Phone & Fax Numbers: _____

Consumer Details

Age between 16 and 65 years ☐

Name: _____

D.O.B. _____ **UR No:** _____

Address: _____

_____

Phone & **Mobile Numbers**: _____

Service Requested	☐ **Individual** CBT - *Complete relevant section* below
	☐ **MBCT Group** - *Complete relevant section below*
Note:	**Psychiatrist referrals for 291s should be directed to Cramond Private Clinics** (Fax 8222 6564) **CTAD does not provide assessments for medico-legal reports.**

INDIVIDUAL CBT- based Therapy Indications

(CTAD is a specialist service for primary Axis I DSM-V Anxiety or Major Depressive Disorders)

Please indicate which of the following applies to the consumer. He/she: ***Tick***

- Has recurrent, unexpected panic attacks & has worried about these attacks for at least 1 month ☐
- Has agoraphobia: avoids places or situations for fear of having anxiety symptoms ☐
- Has a specific phobia (*e.g.,* blood/injury, heights, claustrophobia, driving) ☐
- Has social anxiety: being humiliated, embarrassing him/herself or showing anxiety around unfamiliar people or fears being criticized or negatively judged by others ☐
- Has recurrent obsessions or compulsions he/she recognises are excessive or unreasonable (eg excessive handwashing, checking and other repetitive rituals) ☐
- Has experienced *distressing* dreams, intense recollections, flashbacks or physical reactions *in the past month* re-experiencing an event that involved actual or threatened death or serious injury to him/her (or him/her witnessing such an event) ☐
- Has been excessively anxious or worried about a range of issues (and found it difficult to control the worry) more days than not *for at least the last 6 months* ☐
- Been consistently depressed or down, less interested in most things, or less able to enjoy the things he/she used to most of the day, nearly every day for the past 2 weeks ☐

MBCT Group Indications

- Has recurrent episodes of Major Depression ☐
- Has a diagnosis of Generalised Anxiety Disorder which has not fully responded to CBT or medication ☐

Relevant information about presenting problem

USEFUL GUIDE for assessing SUITABILITY FOR CTAD

Please indicate which of the following applies to the consumer. He/she:

	Yes	*No*
• Has had 3 or more standard drinks nearly every day in the past month	☐	☐
• Has met criteria for Alcohol dependence in the past 12 months and been intoxicated with alcohol during the past 3 months	☐	☐
• Has had difficulty controlling their use of illicit or prescription medications in the past 3 months	☐	☐

If the answer to any of the above is 'yes', consider Drug & Alcohol Services South Australia (DASSA) instead

• Has cognitive difficulties (*e.g.,* Low IQ, attention, reasoning, memory difficulties)	☐	☐
• Has been engaged in antisocial behaviours in the last 12 months	☐	☐
• Has a pervasive pattern of *unstable* interpersonal relationships and self-image and markedly reactive mood and impulsivity (include current self-injuring)	☐	☐
• Has failed to attend one of the last 3 scheduled appointments with you without notice	☐	☐

If the answer to any of the above is 'yes', it would be unusual for the consumer to benefit from the focussed psychotherapy CTAD provides. If you feel the consumer would benefit from cognitive therapy despite these characteristics, please call 8222 8100 to discuss the referral with the Team Manager.

• Is willing to attend 8-20 sessions of psychotherapy and engage in tasks between sessions as agreed on with his/her therapist	☐	☐

Current medication:

Other mental health/counselling providers involved:

NB: If the consumer is currently accessing other counselling/psychotherapy services, please provide rationale for CTAD's involvement (*e.g., Consumer plans to leave other service provider***)**

Special Needs (*e.g. Interpreter)***:**

Referral Agent Name:

Address:

Phone Number: Fax Number:

Setting: (*e.g*., GP, Cramond, ACIS)

GP's Name/Address/ Ph No:

If referrer is a GP, referrals to CTAD can be made under the Medicare 2710 item number.

If a mental health care plan has been devised, is a copy attached? ☐ Yes ☐ No