Referral to *Mindfulness with Dr. Walsh:*
from relaxation to resilience

Date :____________________

Dr Chris Walsh
Church Street Consulting Suites
Suite 8 / 140 Church St
Richmond VIC 3121

Dear Dr Walsh,

Patient Name : ______________________________

Address : ______________________________

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DOB : ______________________________

Medicare: ______________________________

Mobile :

Thank you for seeing the above patient as part of your Mindfulness Group (item 342) to assist with their mental health and manage their condition. This referral is to last -

☐ 12 months **OR** ☐ indefinitely

Past medical conditions, allergies and medications include:

Referring GP Name
& Signature: ______________________________

Date : ______________________________

Provider #: ______________________________

Phone number: ______________________________

Fax number : ______________________________

Practice Address ______________________________

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Practice email : ______________________________