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**P** 3378 9130 **F** 3378 9689  
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ABN 41 536 509 168

**Lilley Place**  
**Referral and Authorisation Form for St Peters Lutheran College Students**  
 Please email to [referrals@lilleyplace.com.au](mailto:referrals@lilleyplace.com.au) or fax to (07) 3378 9689

Client Name	
DOB	
Mobile Number	
Reasons for referral	
<input type="checkbox"/> <b>Safety concerns present?</b>	
Does the student have an active GP Mental Health Care Plan, Paediatrician or Psychiatrist referral, or is willing to get one?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Has the student given consent for Lilley Place to discuss their case with authorised members of St Peters Lutheran College in the interests of collaborative care?	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>If no, the student is still welcome to attend, but we will not be able to share any information with St Peters around their attendance due to privacy restrictions.</i>
Is the student currently an NDIS participant?	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please advise if the participant is Self-Managed, Plan-Managed or NDIA Managed?</i> <hr style="border: 0; border-top: 1px solid black; margin-top: 5px;"/>
<p>To be completed by the Parent/Carer/Guardian of the student mentioned above.</p> <p>I _____, authorise the above student to attend Lilley Place for on-campus psychology services. I agree that I will be liable for full payment of all outstanding invoices sent by Lilley Place for this student.</p> <p>Signature _____ Date ____/____/____</p>	