

ARBIAS Neuropsychological Assessment & Intervention Services (NPAIS)
Private Clinic Referral Form

Referral urgency: High Routine

If HIGH, please include a cover letter addressed to the Manager of NPAIS, outlining the nature and urgency of the referral

Date of Referral: _____

Client Information

Name	Address (include postcode)	Phone Number (include mobile)

Date of Birth: __/__/__ Age:__ Country of Birth:_____

Client's preferred language:_____

Interpreter required: YES NO Is the client Aboriginal: YES NO

Torres Strait Islander: YES NO

Please describe the client's current living situation (e.g. type of accommodation, duration at current residence, alone, with partner etc.):

Is there any support provided at the current accommodation: YES NO

If YES, what type of support is provided:_____

Can the client read and write: YES NO

Are there any risks to the neuropsychologist (e.g. physical aggression, triggers):
YES NO If YES, please provide details:

Does the client have any social supports? (E.g. friends, family members, case worker, etc.). If YES, provide details. _____

Referrer Details

Referring Person and Position: _____

Agency: _____

Address (include mailing address if different): _____

Telephone: _____ Mobile: _____ Fax: _____

Email: _____

Please see website guidelines on referrals for further information to assist with the referral process or contact arbias (P): 03 8388 1222 (E): npais@arbias.com.au

Why are you referring this person for neuropsychological assessment? _____

Are there any specific issues that you would you like addressed in the assessment report? _____

If the assessment report has been requested by the court, please describe or attach details of the nature of the matter and any pending charges: _____

Date of next court appearance: _____

Date report required by the referrer: _____

Please tick the areas of potential risk factors or known ABI

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> Traumatic (MVA / Assault) | <input type="checkbox"/> Alcohol | <input type="checkbox"/> Brain Tumour |
| <input type="checkbox"/> Hypoxic (lack of oxygen) | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Brain Surgery | <input type="checkbox"/> Brain Infection | <input type="checkbox"/> Substance |
| <input type="checkbox"/> Other (specify : _____) | | |

Please provide details of the ABI (e.g. date of injury, hospitals attended, and treatment required): _____

Has the client previously had any of the following? If YES, provide details and attach any relevant reports/documentation:

- Neuropsychological/Cognitive Assessment
- Brain Imaging (CT or MRI)
- Psychological/Psychiatric Assessment
- Alcohol or Substance Detoxification/Rehabilitation
- Other relevant psychosocial background information

Details: _____

If known, please list any current or past medical illnesses and any current medications. Also include past or current psychiatric/mental illnesses and emotional difficulties/issues: _____

Does the person have significant current or a past history of alcohol or substance use? YES NO

If YES, please describe: _____

Please state the client's current source of income:

- | | | |
|--|---------------------------------------|---|
| <input type="checkbox"/> Paid employment | <input type="checkbox"/> Retired | <input type="checkbox"/> Disability Support Pension |
| <input type="checkbox"/> Aged Pension | <input type="checkbox"/> Unemployment | <input type="checkbox"/> Sickness Benefit |
| <input type="checkbox"/> Compensation (e.g. TAC) | | <input type="checkbox"/> Other: _____ |

Does the client have any of the following:

A financial administrator	YES <input type="checkbox"/>	NO <input type="checkbox"/>
A legal guardian	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Bills/Rent paid via Direct Debit or Centrepay	YES <input type="checkbox"/>	NO <input type="checkbox"/>

If YES, provide relevant details: _____

General Information

Highest educational achievement (Year level): _____

Were any year levels required to be repeated, remedial support provided, or learning difficulties identified? YES NO Details: _____

Current employment (include duration): _____

Past occupational history: _____

Are there any current child protection issues relevant to the current referral?

YES NO Details: _____

Other Services Involved

Please list any other relevant services involved that may require a copy of the assessment report (pending the client's consent).

Name: _____

Agency: _____

Address: _____

Telephone: _____ Fax: _____

Mobile: _____ Email: _____

Name: _____

Agency: _____

Address: _____

Telephone: _____ Fax: _____

Mobile: _____ Email: _____

Name: _____

Agency: _____

Address: _____

Telephone: _____ Fax: _____

Mobile: _____ Email: _____

Please attach details of additional services if there is insufficient space on this form

Medical Information

Please forward to the client's General Practitioner for completion

Client name, date of birth and address: _____

Dear Dr,

Please complete the relevant sections (or attach a Patient Summary Sheet) for the above mentioned client in preparation for their neuropsychological assessment and return the document to ARBIAS Neuropsychological Assessment & Intervention Services (NPAIS) PO Box 5002, Brunswick North, Vic, 3056 Telephone (03) 8388 1222 Facsimile (03) 9387 9925

Please see arbias website for further information pertaining to the referral process and details of the neuropsychological assessment, or contact arbias (W) www.arbias.org.au (P): 03 8388 1222 (E): npais@arbias.com.au

GP Name and Address: _____

Medical history: _____

If any history of brain impairment or injury, please provide details (e.g. duration of coma/PTA, hospitals attended):

Previous investigations (e.g. CT, MRI Brain – attach reports if available): _____

Current medications: _____

Any other relevant details: _____

It is standard practice for the assessment report to be forwarded to the client's GP (contingent on the client's consent)