

ARBIAS Neuropsychological Assessment & Intervention Services (NPAIS)
Standard Referral Form

If the referral relates to a legal matter (excluding guardianship and administration issues), please refer to the 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? _____

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: _____

Please list any current or past medical illnesses and any current medications. Also include past or current psychiatric/mental illnesses and emotional difficulties/issues:

Is there a history of significant alcohol or substance use? YES NO
 If YES, please provide details in the table below:

E.g. Alcohol, cannabis, amphetamines (e.g. speed, ice,), opiates (e.g. heroin, morphine), cocaine, ecstasy, GHB, hallucinogens (e.g. LSD), benzodiazepines (e.g. Valium, Xanax), solvents (e.g. paint, glue, petrol), or any other substance

Substance					
Age first used					
Age of first regular use					
Number of days used in the last two weeks					
Average daily intake/use					
When last used					

Please comment on any other issues about AOD use that may be relevant: _____

Please state the client's current source of income:

- Paid employment Retired Disability Support Pension
 Aged Pension Unemployment Sickness Benefit
 Compensation (e.g. TAC) Other: _____

Does the client have any of the following:

- A financial administrator YES NO
 A legal guardian YES NO
 Bills/Rent paid via Direct Debit or Centrepay YES NO

If YES, provide relevant details: _____

Participation

To what extent does the person participate in the following life areas?

Life areas	Fully	Partially	Not at all	Not known
Getting around inside	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using transport	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maintaining family relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maintaining social relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recreation or leisure activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Working	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Handling money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Support Needs

How often does the person need HELP or SUPERVISION with ACTIVITIES or PARTICIPATION in the following life areas?

Life Areas	Unable to do or always needs help in this area	Sometimes needs help or supervision in this area	Does not need help in this area but uses aides	Does not need help in this area and does not use aides
Self care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mobility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interpersonal interactions & relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning, applying knowledge and general tasks and demands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Community (civic) & economic life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Domestic life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Working	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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)