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SECTION 1: CLIENT INFORMATION:

Client Name	Address (incl postcode)	Phone Number (incl mobile)

Date of Birth: _____ Age: _____

Country of birth: _____

Clients preferred language: _____

Cultural affiliation/Koori?

Interpreter Required: YES NO

Has your client had a Neuropsychological Assessment in the last 12 months ago? YES NO

Where/When? _____

**SECTION 2: REFERRING AGENCY/PRACTITIONER
AND OTHER CURRENT RELEVANT SERVICES AND PROFESSIONAL SUPPORTS**

Referring Agency/Practitioner: _____

Address: _____

Phone: _____ Fax: _____

Reason for referral:

Secondary Consultation Case Management

Source of Referral:

- Self
- Family, significant other, friend
- GP/medical practitioner
- Specialist aged or disability assessment team/services (e.g. ACAT)
- Comprehensive HACC assessment authority
- Community nursing services
- Hospital (public)
- Psychiatric/mental health services or facility
- Extended care/rehabilitation facility
- Palliative carer facility/hospice
- Aboriginal health services

Other current relevant services and professional supports:

Name of GP: _____ Phone: _____

Name of Social Worker: _____ Phone: _____

Name of Neuropsychologist: _____ Phone: _____

Emergency Contact Details:

Name: _____

Relationship: _____ Phone: _____

SECTION 3: LEGAL HISTORY

(tick one)

Criminal/Civil Charges Pending: Yes No

Bail Conditions: Yes No

Restraining Orders: Yes No

Other: _____

SECTION 4: PSYCHOSOCIAL HISTORY

Marital Status: (tick one)

- never married married
- married, de-facto divorced
- separated re-married

Family Relationship/Children (eg. *child care responsibilities, Child Protective Services involvement*):

Accommodation (eg. *stable, supportive, crisis accommodation, homeless/at risk of homeless, substance use in household*): _____

Finances/ Employment (eg. *Source of income, employment history*):

- | | |
|---|--|
| <input type="checkbox"/> Aged Pension | <input type="checkbox"/> Veterans' Affairs pension |
| <input type="checkbox"/> Disability Support pension | <input type="checkbox"/> Carer Payment (pension) |
| <input type="checkbox"/> Unemployment –related benefits | <input type="checkbox"/> Other gov. pension or benefit |
| <input type="checkbox"/> No gov. pension or benefit | |

Education/ Training (eg. highest level of education achieved, literacy skills):

Recreational Interests (eg. hobbies, sports, music, gym, reading, fishing):

SECTION 5: ALCOHOL AND OTHER DRUG HISTORY (TICK PREFERRED BOX)

Drug (s) of Choice:

History of Other Drugs Used: Yes No

Depressants:

- Alcohol
- Minor Tranquillisers/benzodiazepines (Rohypnol, Valium, Serepax, Mogadon, Normison, Euhypnos)
- Heroin
- Cannabis
- Solvents and inhalants (petrol, glue, chrome paint, lighter fluid)

Stimulants:

- Amphetamines
- Cocaine
- Nicotine
- Caffeine

SECTION 6: MEDICAL HISTORY (TICK PREFERRED BOX)

Current issues:

- Allergies
- Seizure/fits/ epilepsy
- Liver Disease
- Dental
- Head Injuries
- Gastrointestinal problems
- Cardiac Problems
- Respiratory
- Chronic Pain
- Skeletal injuries
- Diabetes
- Pregnancy
- ABI (trauma, drug use, infection, tumor, hypoxia)

General Hospital Admissions and frequency: _____

Current Medication: _____

SECTION 7: MENTAL HEALTH HISTORY (TICK PREFERRED BOX)

Previous psychiatric history/diagnosis/assessments:

Abnormal thought process: Confusion Disorientation

Mood: Elevated Depressed Flat

Suicide/Self harm risk assessment:

- Sense of hopelessness/worthlessness?
- Ideation of killing/harming yourself?
- Intent to kill/harm yourself?
- Plan (How would you do it?)
- Lethality (Is the method likely to be lethal?)
- Accessibility?
- Previous attempts?

Is a full psychiatric assessment required? Yes No

Currently Receiving treatment? Yes No

Treatment receiving: _____

Name: _____ Phone: _____

SECTION 8: CASE SUMMARY

Summary of client, covering essential issues (e.g. general presenting problem, relevant A&D, medical and psychosocial history-including provisional diagnosis, clients motivation, barriers to treatment):

Main issues identified by worker (to assist with formulation of Individual Care Plan):

Action to be taken (summarise the initial action required)

Refer to Agency/Health Professional	For	Client Consent Yes/No	Date

Signature: _____

Date: _____

Name: _____

Position: _____