arbias
ABI Specialist Services - Victoria
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ABN 49 307 923 403

Victoria Intake and Response Services Referral Form	
COMPLETING THIS FORM: to place a cross in a box, double click the mouse in the box and select "checked".	
Date of referral:	
Services referring to	☐ Neuropsychological Assessment ☐ Community Facilitation (Case Management) ☐ Housing Services ☐ Flexible Outreach
Has the person consented to this referral?	☐ Yes Date: ☐ No Please note the referral will not be accepted if the person does not consent.

Client Details			
Name (include alias if applicable)			
Address			
Post code		Gender	
Date of birth		Age	
Phone			
Is the person Aboriginal or Torres Strait Islander?	☐ Yes ☐ No		
Country of birth		Nationality	
Interpreter required?	☐ Yes ☐ No If Yes, please list what language or sign language:		
Describe the clients current living situation (type of accommodation, duration of residence, alone, with partner etc)			
Is there any support provided at current accommodation?	☐ Yes ☐ No If Yes, please provide details:		

Can the person read and write?	☐ Yes ☐ No	Comments	
Does the client have any social supports? (Friends, family members, case worker etc)			
Emergency Contact Details			
Name and relationship to client			
Address			
Phone			
Referrer Details			
Name and organisation			
Address			
Phone/Mobile		Fax	
Email			
Please outline your current role with the client:			

Details of ABI (Acquired Brain Injury)

☐ Stroke	☐ Hypoxic (reduction of oxygen)
☐ Brain Infection	☐ Brain Surgery
☐ Brain Tumour	☐ Epilepsy
☐ Traumatic (MVA/Falls)	☐ Suicide Attempts/ Blood Loss
☐ Assaults	☐ Professional fights
☐ Alcohol related	☐ Substance related
☐ Other (please specify)	

General Information	
Please state the client's current source of income:	
Is there a Legal Guardian or Administrator? Please provide name and contact details: **Please note for NPAIS referrals, Guardian MUST SIGN Referral declaration*	☐ Yes ☐ No

Employment/Education	Highest educational achievement (year level): Current occupation and duration: Previous employment history:
Psychosocial History	Please provide relevant information on the person's martial status, relationships, family etc
Recreational interests	
Legal status	☐ None ☐ Bond ☐ Parole ☐ CCO/CBO – Please attach a copy ☐ Child custody/ family dispute ☐ Other (please specify) Specify details of above:
Medical information Please list any current or past medical illnesses: Current medications:	
Please list any current or past psychiatric/mental illnesses:	

Current medications:	

Current and previous substance use *DO NOT COMPLETE THIS QUESTION if you are also completing in Appendix 1: arbias NPAIS referral form*	Please list substances Current use? Frequency of use? Interventions:
Is the client involved with a DHS service?	Please specify:
Is there a history of violence or sexual behaviours?	Please specify any risk factors:

Other Services Involved

Please list formal and informal supports involved:

Name of service	**Service type**	**Duration of involvement**	**Contact information**	**Consent to contact?**

MUST BE COMPLETED – Requirement of DHS funding

Support Needs

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

Life Areas	Unable to do OR always need help in the area	Sometimes needs help OR supervision in the 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	☐	☐	☐	☐
Mobility	☐	☐	☐	☐
Communication	☐	☐	☐	☐
Interpersonal interactions & relationships	☐	☐	☐	☐
Learning, applying knowledge and general tasks and demands	☐	☐	☐	☐
Education	☐	☐	☐	☐
Community (civic) & economic life	☐	☐	☐	☐
Domestic life	☐	☐	☐	☐
Working	☐	☐	☐	☐

Participation

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

Life Areas	Fully	Partially	Not at all	Not known
Getting around outside	☐	☐	☐	☐
Using Transport	☐	☐	☐	☐
Maintaining family relationships	☐	☐	☐	☐
Maintaining social relationships	☐	☐	☐	☐
Recreation or leisure activities	☐	☐	☐	☐
Working	☐	☐	☐	☐
Handling money	☐	☐	☐	☐

Appendix:
Neuropsychological Assessment & Intervention Services (NPAIS)

COMPLETING THIS FORM: to place a cross in a box, double click the mouse in the box and select "checked"

If the referral relates to a **legal matter** (excluding guardianship and administration), please refer to the **Private Clinic Referral Form**.

Referral urgency: ☐ **HIGH** ☐ ROUTINE

Please note: **HIGH** urgency referrals must include a cover letter addressed to the NPAIS Manager outlining the urgency of the nature and urgency of the referral.

Referral Question Section Please answer **ALL** questions in this section	
Why are you referring the client for a neuropsychological assessment?	
What are the difficulties that the client is currently experiencing that you think may be related to possible brain impairment?	☐ Memory ☐ Attention/Concentration Problems ☐ Behavioural Concerns/Personality Changes ☐ Problem Solving ☐ Visual or Spatial Problems ☐ Other (please specify)
What areas of concern would you like addressed in the assessment report?	☐ Recommendations/strategies for informal and formal supports ☐ Access to services (housing, support agencies etc) Please specify: ☐ Administration order or Guardianship? Please specify: ☐ Other Please specify:

Is the report going to be used for a particular purpose?	☐ VCAT – Is there a hearing date set? Date: ☐ Access to support services ☐ Target Group Assessment (for disability funded services) ☐ Behavioral support (e.g. Case Management, participation in community programs etc) ☐ Community Corrections Order (CCO) ☐ Other (please specify)
Are there any risks to the neuropsychologist? (Physical aggression, triggers)	Please specify:

Alcohol and Other Drug (AOD) History (complete only if applicable)

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), inhalant's (e.g. paint, glue, petrol), or any other substance.*

Substance of choice:

Substance				
Age first used				
Age of first regular use				
When last taken				
Total length of heavy use (months/years)				
Overdoses or loss of consciousness? **How often?** **How long?**				

Has the client had any of the following?	☐ Neuropsychological/Cognitive Assessments ☐ Brain Imaging (CT or MRI) ☐ Psychological/Psychiatric Assessment or admissions ☐ Alcohol or Substance detoxification/Rehabilitation Please provide details and attach any relevant reports/ documentation:

Referrer Checklist	
Please complete before submitted referral form	
Have all questions in the Referral Question Section answered?	☐ Yes ☐ No
Have you attached any supporting documents to the application?	Please specify:
Have you sent the medical information page (overleaf) to the client's GP?	☐ Yes ☐ No

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ABI Specialist Services - Victoria

Medical Information	
Referrer - *Please fill in client's name & date of birth details and then fax or email this form to the clients GP for completion*	
Dear Dr, The following client has been referred to arbias for a neuropsychological assessment. **Client name**: ..... **Date of Birth:** ..... Please complete the section below or attach a Patient medical Summary This information will provide important background information in anticipation of their neuropsychological assessment.	
GP Name & Address	
Medical History *Current medications*	
Is there a history of brain impairment or injury? (Duration of coma/PTA, hospitals attended)	*Please specify*
Previous investigations (CT, MRI Scans)	*Please specify*
Please specify any other relevant details	
GP Signature	
Date	
Return completed form to:	**Arbias- Intake and Response** **Fax: (03) 9387 9925** **Email: intakeandresponse@arbias.com.au**

CONSENT FORM arbias CLIENT SERVICES

What does Consent mean?
There are a range of services and activities that you may participate in (see below). arbias must ensure that you understand what this means and that you have given your permission to being involved in any or all of these activities. This means that you want and need the service (eg case management), that you are willing to abide by the guidelines of the service and that you are willing to freely participate in the service.

- You must sign a consent form that tells us you want to participate in the service.
- You are happy for us to give information to other relevant people. (such as a doctor, a solicitor, another service provider).
- You are happy for us to seek information from (such as a doctor, a solicitor, another service provider).
- You can change your mind at any time and we will update the form. Otherwise, the form is re-signed by you every 12 months.

I ……..
(Name)
of

……..
(Address)

……..

consent to voluntarily be referred to and participate in ***arbias*** services:

- ❑ Community Facilitation (Case Management)
- ❑ Flexible Outreach/Direct Support
- ❑ Housing Services
- ❑ Community Programs
- ❑ Neuropsychology/Initial Community Participation Assessment
- ❑ Clinical Services
- ❑ Secondary Consultation

I have received the My *arbias* Workbook Yes / No (Please circle)

Client Signature: …….. *Date:* ……..

Witness Signature: …….. *Date:* ……..

Consent for Release and Gaining Information

I acknowledge that this will involve ***arbias*** having links with other services, to obtain information and advocate on my behalf as necessary, including the potential release of relevant information. This is to generate the planning of goals for the future.

I consent to arbias releasing or gaining information with the following services/people:

Releasing	Gaining
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I know that my personal information will reman confidential and be kept secure by arbias, unless;

1. It is subpoenaed by a court, or
2. Failure to disclose information would place me or another person at risk; or
3. I consent for the information to be released to another person or organisation.

I understand that that de-identified information (**with my name removed**) about my support needs, and basic demographic information may be used by ***arbias*** in data collection and research for the purpose of improving ***arbias*** services.

Client Signature: ..... *Date:* .....

Witness Signature: ..... *Date:* .....

Consent to use a photo and/or information, audio or video for media, education and/or training purposes

Consent for

- ☐ Photos
- ☐ Video/audio
- ☐ Stories about myself and my life

To be used in arbias documentation including:

- ☐ arbias website
- ☐ Annual report
- ☐ Brochures
- ☐ Newsletters
- ☐ Social Media

Client Signature: ..... *Date:* .....

Witness Signature: ..... *Date:* .....

Activities of Daily Living Questionnaire
Johnson, Barion, Rademaker, Rehkemper, and Weintraub (2004)

Name:	Administered by:	Date:

Instructions: Circle one number for each item

SELF-CARE ACTIVITIES

1. **Eating**
   - 0 No problem
   - 1 Independent, but slow or some spills
   - 2 Needs help to cut or pour; spills often
   - 3 Must be fed most foods
   - 9 Don't know
2. **Dressing**
   - 0 No problem
   - 1 Independent, but slow or clumsy
   - 2 Wrong sequence, forgets items
   - 3 Needs help with dressing
   - 9 Don't know
3. **Bathing**
   - 0 No problem
   - 1 Bathes self, but needs to be reminded
   - 2 Bathes self with assistance
   - 3 Must be bathed by others
   - 9 Don't know
4. **Elimination**
   - 0 Goes to the bathroom independently
   - 1 Goes to the bathroom when reminded; some accidents
   - 2 Needs assistance for elimination
   - 3 Has no control over either bowel or bladder
   - 9 Don't know
5. **Taking pills or medicine**
   - 0 Remembers without help
   - 1 Remembers if dose is kept in a special place
   - 2 Needs spoken or written reminders
   - 3 Must be given medicine by others
   - 9 Does not take regular pills or medicine **OR** Don't know
6. **Interest in personal appearance**
   - 0 Same as always
   - 1 Interested if going out, but not at home
   - 2 Allows self to be groomed, or does so on request only
   - 3 Resists efforts of caretaker to clean and groom
   - 9 Don't know

HOUSEHOLD CARE

7. **Preparing meals, cooking**
   - 0 Plans and prepares meals without difficulty
   - 1 Some cooking, but less than usual, or less variety
   - 2 Gets food only if it has already been prepared
   - 3 Does nothing to prepare meals
   - 9 Never did this activity **OR** Don't know
8. **Setting the table**
   - 0 No problem
   - 1 Independent, but slow or clumsy
   - 2 Forgets items or puts them in the wrong place
   - 3 No longer does this activity
   - 9 Never does this activity **OR** Don't know
9. **Housekeeping**
   - 0 Keeps house as usual
   - 1 Does at least half of his/her job
   - 2 Occasional dusting or small jobs
   - 3 No longer keeps house
   - 9 Never did this activity **OR** Don't know
10. **Home maintenance**
    - 0 Does all tasks usual for him/her
    - 1 Does at least half of usual tasks
    - 2 Occasionally rakes or some other minor job
    - 3 No longer does any maintenance
    - 9 Never did this activity **OR** Don't know
11. **Home repairs**
    - 0 Does all the usual repairs
    - 1 Does at least half of usual repairs
    - 2 Occasionally does minor repairs
    - 3 No longer does any repairs
    - 9 Never did this activity **OR** Don't know
12. **Laundry**
    - 0 Does laundry as usual (same schedule, routine)
    - 1 Does laundry less frequently
    - 2 Does laundry only if reminded; leaves out detergent, steps
    - 3 No longer does laundry
    - 9 Never did this activity **OR** Don't know

EMPLOYMENT AND RECREATION

13. **Employment**
    - 0 Continues to work as usual
    - 1 Some mild problems with routine responsibilities
    - 2 Works at an easier job or part-time; threatened with loss of job
    - 3 No longer works
    - 9 Never worked **OR** Retired before illness **OR** Don't know