Referral and Background Information Form

Referrer: Name: _____ Agency: _____

Address: _____

Ph: _____ Email / Other Contact: _____

Client Details (Mandatory): ***Referral Date:*** _____

Name: _____ DOB: _____

Sex: ☑ **M** ☐ **F** ☐ **N/A** ☐ **Not known** ☐ **Other:** _____

Aboriginal or Torres Strait Islander origin? ☐ **No** ☐ **Aboriginal** ☐ **Torres Strait Islander**

Are financial supports in place?

☐ **No (self-funded)** ☐ **Insurance/WorkCover** ☐ **NDIS -** *Number:* _____

☐ **Other (please specify) :** _____ *Plan period*: _____

_____ *Plan Management Option*:_____

Address:

_____

Phone Number: _____ Email / Other Contact: _____

Interpreter Required: ☐ Language: _____

Preferred Appointment Day/Time: _____

Preferred Appointment Location: ☐ **Strathfield South** ☐ **St Leonards** ☐ **Home/On-site required**

Reason for Referral (Mandatory): ☐ **Assessment/Testing** ☐ **Remediation/Intervention**

Neuropsychological Complaints / Suspected Neuropsychological Weaknesses:

Memory ☐ Details: _____

Concentration ☐ Details: _____

Communication ☐ Details: _____

Visuo-spatial ☐ Details: _____

Executive ☐ Details: _____

Behaviour ☐ Details: _____

Personality ☐ Details: _____

Problems with:

Work ☐ Details: _____

Study ☐ Details: _____

Driving ☐ Details: _____

Independent Living ☐ Details: _____

Decision-Making ☐ Details: _____

Law ☐ Details: _____

Relationships ☐ Details: _____

Other ☐ Details: _____

Neurological History:

History of Head Injury: ☐ Details:_____

History of Stroke: ☐ Details:_____

History of other Acquired Brain Injury ☐ Details:_____

History of Learning Disorder ☐ Details:_____

History of Attention Deficit Disorder ☐ Details:_____

Suspicion of Dementia ☐ Details:_____

Other ☐ Details:_____

Substance Use History:

History of significant Alcohol use: ☐ Details:_____

History of significant Cannabis use: ☐ Details:_____

History of significant Stimulant use ☐ Details:_____

History of significant Opiate use ☐ Details:_____

History of significant Cigarette smoking ☐ Details:_____

History of significant Other drug use ☐ Details:_____

Previous or Current Mental Health Diagnosis and/or Treatment:

Depression ☐ Details: _____

Anxiety ☐ Details: _____

Psychosis ☐ Details: _____

Other ☐ Details: _____

Current Medications:

Antidepressants: ☐ Details: _____

Antianxiety / Benzodiazepines: ☐ Details: _____

Antipsychotic: ☐ Details: _____

Other: ☐ Details: _____

Other Details: