ANTS ADVANCED NEUROPSYCHOLOGICAL TREATMENT SERVICES Knowledge, Compassion, Excellence

Referral and Background Information Form

Referrer: Name: _____ Agency: _____

Address: _____

Ph: _____ Email / Other Contact: _____

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

Name: _____ DOB: _____

Sex: ❒ **M** ❒ **F** ❒ **Not known** ❒ **Not applicable**

Are financial supports in place?

❒ **No (self-funded)**

❒ **Yes. Please specify:** _____

_____

Is the person of Aboriginal or Torres Strait Islander origin?

❒ **No** ❒ **Yes, Aboriginal** ❒ **Yes, Torres Strait Islander**

Address: _____

Ph: _____ Email / Other Contact: _____

Language: _____ Interpreter Required: Y / N

Preferred Appointment Day: _____ Preferred Appointment Time: _____

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

_____

_____

Neuropsychological Complaints / Suspected Neuropsychological Weaknesses:

Memory Y / N Details: _____

Concentration Y / N Details: _____

Communication Y / N Details: _____

Visuo-spatial Y / N Details: _____

Executive Y / N Details: _____

Behaviour Y / N Details: _____

Personality Y / N Details: _____

Problems with:

Work Y / N Details: _____

Study Y / N Details: _____

Driving Y / N Details: _____

Independent Living Y / N Details: _____

Decision-Making Y / N Details: _____

Law Y / N Details: _____

Relationships Y / N Details: _____

Neurological History:

History of Head Injury: Y / N Details:_____

History of Stroke: Y / N Details:_____

History of other Acquired Brain Injury Y / N Details:_____

History of Learning Disorder Y / N Details:_____

History of Attention Deficit Disorder Y / N Details:_____

Suspicion of Dementia Y / N Details:_____

Other Y / N Details:_____

Substance Use History:

History of significant Alcohol use: Y / N Details:_____

History of significant Cannabis use: Y / N Details:_____

History of significant Stimulant use Y / N Details:_____

History of significant Opiate use Y / N Details:_____

History of significant Cigarette smoking Y / N Details:_____

History of significant Other drug use Y / N Details:_____

Previous or Current Mental Health Diagnosis and/or Treatment:

Depression Y / N Details: _____

Anxiety Y / N Details: _____

Psychosis Y / N Details: _____

Other Y / N Details: _____

Current Medications:

Antidepressants: Y / N Details: _____

Antianxiety / Benzodiazepines: Y / N Details: _____

Antipsychotic: Y / N Details: _____

Other: Y / N Details: _____

Other Details: _____

_____

_____