**ADULT GENERAL DIAGNOSTIC PROGRAM**

**REFERRAL FOR NEUROPSYCHOLOGY AND/OR SPEECH PATHOLOGY ASSESSMENT**

***CONFIDENTIAL***

**Please complete form in Microsoft Word & return via email to:** **Graylands.Neurosciences@health.wa.gov.au**

*To complete the form, type directly into the highlighted grey box (you don’t need to click in the grey field or make the cursor appear) or click on the relevant boxes. Once you have completed the form you need to save the changes and email the saved document as an attachment*

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| **CLIENT’S DETAILS:** |
| Surname:  |       | First Name/s:  |       |
| DOB:  |       | Gender:  |       |
| Mobile Number:  |       | Home Number:  |       |
| Address:  |       |
| Email Address: |       |  |  |
| Language(s) spoken:  |       | Interpreter Required: Yes | [ ]  / No [ ]   |
| Is the client of  | [ ]  Aboriginal or | [ ]  Torres Strait Islander origin |
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| Does the client have a Guardian or Enduring Guardian with the function of medical decision making? Yes [ ]  No [ ]   | If yes,  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Has the Guardian / Enduring Guardian consented to the referral? Yes [ ]  No [ ]  N/A [ ]  |

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|  **DATE OF REFERRAL: THIS REFERRAL IS FOR:**  |
| [ ]  Neuropsychology assessment  | [ ]  Speech Pathology Assessment |
| [ ]  Joint Neuropsychology and Speech Pathology Assessment *Please note psychiatry / neuropsychiatry and neurology are not available on this program* |
| Is the patient aware of this referral [ ]  Yes [ ]  No, (please give reason) \_\_\_\_\_\_  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Best person to contact to book the appointment: [ ]  Client or [ ]  Other (complete below)Client has consented to contact with: Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| **REASON FOR REQUESTING A NEUROPSYCHOLOGICAL / SPEECH PATHOLOGY ASSESSMENT (please complete all sections):** |
| Presenting problems (include duration, frequency, previous history):      Why do you want this assessment?       |
| What is the specific referral question/s?       |
| How will the assessment help with the client’s management?       |

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| **PAST NEUROLOGICAL/MEDICAL/PSYCHOLOGICAL HISTORY:** |
|       |

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| **CURRENT MEDICATION REGIME AND INVESTIGATIONS:** |
| Current dose & length of use:  |       |
| Results of any CT, MRI, EEG etc:  |       |
| *Please attach any available investigative reports or psychological test results* |

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| **OTHER RELEVANT ISSUES:** |
| Are there any medicolegal issues?:  | Yes [ ]  No [ ]   |
| If yes, details:       |
| Is the client registered with NDIS?: | Yes [ ]  No, but is/ will be applying [ ]  No [ ]   |
| Is this assessment required by another agency?: | Yes [ ]  No [ ]   |
| e.g. Centrelink [ ] , NDIS [ ] , SAT [ ] , other      ? |
| Is the client receiving (or applying for) any insurance payments?: | Yes [ ]  No [ ]   |
| e.g. Total and Permanent Disability [ ]  , Income Protection Insurance [ ]  , other      ? |
| Are you aware of any current factors that may affect a lengthy testing session or put clinicians at risk (e.g., agitation, aggressive behaviours, OCD, physical limitations etc)?     Are there any other issues we should be aware of? (e.g., scheduled SAT hearing, patient going overseas, intended inpatient admission or discharge etc)?      |

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| **CURRENT AND PREVIOUS AGENCY/HEALTH PERSONNEL INVOLVEMENT (incl. GP):** |
| Contact person & agency: |       | Contact Number |       |
| Contact person & agency: |       | Contact Number |       |
| Contact person & agency: |       | Contact Number |       |
| Contact person & agency: |       | Contact Number |       |
| Are current agencies aware of the referral to NSU?: | Yes [ ]  No [ ]   |

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| **REFERRER’S DETAILS (please note that this needs to be a medical practitioner – see over page for referral criteria):** |
| Name:  |       | Position:  |       |
| If Registrar, Consultant: |       | Contact Number: |       |
| Agency:  |       | Address:  |       |
| Email:  |       |
| Fax: |       |
| **Medical specialists: Please include your clinic letters of assessment.** |

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| Please call the Neurosciences Unit on 6159 6464 to check the current wait list.If you are unsure if a referral is appropriate for our service, please ask to speak with the Adult General Diagnostic Program Duty Psychologist to discuss. |

**Please return this form via:**

Email (preferred) **Graylands.Neurosciences@health.wa.gov.au**

Faxed to us directly on 9385 6813 or mailed to:

Post Office Private Bag No.1 CLAREMONT WA 6910

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