**Neurosciences Unit
Child and Adolescent Neurocognitive Assessment Clinic (CANAC) Referral Form**

***Confidential*** *– Please print clearly*

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| 1. **REFERRER’S DETAILS:**
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| Referrer: | Position/Title: | Telephone: |
| Agency: | Email: |
| Address: |
| 1. **CLIENT’S DETAILS:**
 |
| Client’s Name: |
| Date of Birth: | UMRN (if known): |
| Is child known by any other name? | Gender: |
| Home Address: |
| Current School: | Year Level: |
| Language Other Than English: |  | Interpreter Required? | [ ] Y / [ ] N |
| Aboriginal or Torres Strait Islander: | [ ]  Y / [ ] N |
| 1. **RELEVANT FAMILY INFORMATION**
 |
| [ ]  Nuclear Family | [ ]  Single Parent | [ ]  Blended Family | [ ]  CPFS Involvement |
| Legal Guardian Name: |  | Phone: |
| Relationship to Child: |  | Email: |
| Best Contact Person: |  | Phone: |
| Relationship to Child: |  | Email: |
| Language Other Than English: | Interpreter Required? | [ ] Y / [ ] N |
| Family aware of referral? | [ ] Y/[ ] N | **Note**: Attached consent form signed by parent/guardian authorised to give consent MUST be included with the referral |
| Additional information: |
| 1. **RELEVANT NEUROLOGICAL/MEDICAL/PSYCHOLOGICAL HISTORY:**
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| 1. **RELEVANT SPEECH AND LANGUAGE HISTORY*:***
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| 1. **REASON FOR REFERRAL AND GOALS FOR THE ASSESSMENT(S):**

*Please make referral questions as specific as possible.* |
| **Referral stream** (See section 7a for Records and Reports required to support referral)[ ]  General Assessment query[ ]  Foetal Alcohol Spectrum Disorder (FASD) Assessments(**Referrals by Paediatrician only**; Please see section 7b for additional referral criteria for FASD assessments) |
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| 1. **RECORDS AND REPORTS REQUIRED:**

*The following records are to be included in the referral*. |
| 1. **For all Referrals:**

[ ]  Copy of recent clinic letter (if referrer is from a medical provider)[ ]  Copy of any previous neuropsychology, school psychology, or other cognitive testing reports (if available)[ ]  Copy of any speech and language testing reports (if available)[ ]  Copy of EEG/Neuroimaging reports not on IMPAX; results of genetic tests/sleep studies, etc. |
| 1. **Additional records for FASD Assessments**

[ ]  Evidence of alcohol exposure in utero (in concordance with the Australian Guide to the diagnosis of FASD). If possible, complete and attach a copy of the Audit C tool for details of alcohol exposure in utero.Source of PAE report:[ ] Biological mother [ ]  Immediate family. Specify whom: First-hand witness: [ ] Y/[ ] N[ ]  Foster carer. Specify whom: First-hand witness: [ ] Y/[ ] N[ ] CPFS. Please note if formally documented: [ ] Y/[ ] N[ ]  Police / Birth / Other Hospital records (please circle)[ ]  Results from an assessment of sentinel facial features if completed; or[ ]  Referral for facial photography was completed on \_\_/\_\_/\_\_ |
| Are you aware of any psycho-emotional or behavioural factors that may affect a lengthy testing session? *(e.g. anxiety, agitation, aggressive behaviours, physical limitations etc.)* | [ ] Y/[ ] N |
| Do you believe the child will be comfortable separating from his/her parents/carers during the assessment (*3 - 4 hours*)? | [ ] Y/[ ] N |
| Are there any outstanding medico-legal or other legal/family court issues? | [ ] Y/[ ] N |
| If yes to any of the above, please specify: |
| Current medications (*include* dose *and* length *of use*): |
| **I confirm that all sections of the referral are complete and the following consent forms have been signed by the client’s parent/guardian and attached with this referral.**[ ]  NSU CANAC Consent for Assessment Form[ ]  NSU CANAC Authorisation to Exchange and Release Information Form |
| Please note that waitlists apply. To discuss the suitability of this referral, please phone the Duty Clinician on (08) 6159 6464. |
| Signed by Referrer: |  | Date: |  |
| Consultant Details (if appropriate) |  |

Referrals can be emailed to Graylands.Neurosciences@health.wa.gov.au (preferred) or faxed to 08 9385 6813.