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

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

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| 1. **REFERRER’S DETAILS:** | | | | | | | | | | | | | | | | | | | |
| 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:** | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | |
| 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) | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| 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](mailto:Graylands.Neurosciences@health.wa.gov.au) (preferred) or faxed to 08 9385 6813.