South West Neuropsychology Referral Form

Patient Information

Name: First _____ Surname _____

Date of Birth: _____ Age: _____ Gender: ☐ Male ☐ Female

Address: _____

Best Contact Number: _____

Is client fluent in English: ☐ Yes ☐ No Interpreter required: ☐ Yes

Is your client aware of this referral: ☐ Yes ☐ No

Next of Kin:

Name: _____ Relationship: _____ Phone: _____

Referrer Information

Name: _____ Date of Referral: _____

Address: _____

Phone: _____ Email: _____

Specialty: ☐ GP ☐ Geriatrician ☐ Physician ☐ Neurological Nurse

☐ Psychologist ☐ Paediatrician ☐ Other (eg self-referral)

Relevant Clinical Information

Presenting cognitive and/or psychological symptoms: _____

_____

admin@swneuropsychology.com.au 0415 955 453

Specific referral question: ☐ Confirm/clarify diagnosis ☐ Verify change in cognition

☐ Cognitive strengths/weaknesses ☐ Guide return to work/study/rehab

☐ Decision-making capacity ☐ Post-concussion ☐ Baseline

☐ Strategies to manage cognitive/behavioural issues ☐ Other

Are there any medico-legal issues: ☐ Yes ☐ No

If yes, please describe: _____

Previous investigations

Has the client had a neuropsychological assessment before (if so, *please attach)*?

☐ Yes ☐ No

Date: _____ Place: _____ Contact person: _____

Has the client had any medical investigation(s) in relation to this referral (if so, please attach)?

☐ CT Brain ☐ MRI Brain ☐ PET Brain ☐ SPECT Brain ☐ EEG

If so, date and result: _____

Other Clinical Information

Does the client have:

A psychiatric diagnosis: ☐ Yes ☐ No

A known neurological disorder: ☐ Yes ☐ No

Substance use disorder: ☐ Yes ☐ No

Are there known risks associated with this client (eg aggression) ☐ Yes ☐ No

Other information (e.g. hearing, vision, mobility, medical) ☐ Yes ☐ No

If yes to any of the above, please describe: _____

Thank you for your referral. Dr James will endeavour to be in contact within 48hrs

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