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**E-mail: info@gippslandneuropsych.com**

**Postal: P O Box 106 Sale Vic 3850**

**Clinic: 34 Macarthur St Sale Vic 3850**

**Web:** [**gippslandneuropsych.com**](http://www.gippslandneuropsych.com)

**Ph: 51 44 1065**

**Referral Form**

ABN: 49 393360496

***\*Guidelines for lodging referral form:***

1. **Fill out electronically and email, or send via surface mail to P O Box along with any supporting documentation.**

***Note: Type in the grey boxes and they will expand automatically. Also send supporting documentation by scanning and attaching file to email. If unable to scan and attach supporting documentation, send copies of supporting documentation via surface mail.***

***OR***

1. **Print off form and fill out manually and send via surface mail along with supporting documentation.**

***Note: Sections should be expanded by putting in spacing before printing to allow enough space to fill out form.***

***NOTE: Please ensure that the GP medical summary is attached and financial details are completed, or there will be a delay in processing the referral.***

***If there are any queries deciding which service the client needs, or with filling out this form, please contact us via email, or telephone to arrange an initial needs consultation session.***

***Once the referral is processed, an estimate of cost will be provided in a service agreement, and either an appointment, or an estimation of wait time will be provided.***

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| --- | --- | --- |
| **Date:** | | **Client Name:** |
| **DOB:** | | **Street & postal Address:** |
| **Phone:** | | **Email:** |
| **Brief background history leading to referral *(Why the client is being referred?)****:* | | |
| **What Service does the client require? *(ie neuropsychological assessment, rehabilitation/behavioural support, neuropsychological therapy/counselling/focussed psychological strategies, or both assessment & ongoing treatment?)*** | | |
| **Specific referral question/reason for neuropsychological involvement *(ie diagnostic assistance, capacity, characterisation of cognitive function, rehabilitation goals, behaviour support, mental health, etc):*** | | |
| **GP:** ***A*** ***PRINTOUT OF*** ***A*** ***GP MEDICAL HEALTH SUMMARY THAT INCLUDES CLIENT MEDICAL HISTORY & CURRENT MEDICATION LIST MUST BE PROVIDED, along with GP contact details. Also include any other additional relevant recent test results, including brain imaging, pathology, etc):*** | | |
| **Psychiatric/Psychological history *(include all formal diagnoses)*:** | | |
| **Previous assessment reports and/or test results: Medical or hospital discharge summaries, Neuropsychological, Psychiatric, Psychological, Educational, Allied Health, etc). *Please attach all reports that are available.*** | | |
| **Educational history: *(include highest level of education, any year levels repeated, or learning difficulties, etc).*** | | |
| **History of substance use**: | | |
| **Summary Social Issues** ***(include any issues re family support, accommodation, financial affairs, etc., impacting on mental state and daily living activities):*** | | |
| **Referrer details** | | |
| **Name & Agency** |  | |
| **Address:** |  | |
| **Ph:** |  | |
| **Email:** |  | |
| **Name & details of primary contact if different to referrer** |  | |
| **Support/Care Coordinator** | | |
| **Name & Agency** |  | |
| **Address:** |  | |
| **Ph:** |  | |
| **Email:** |  | |
| **Level of Support being provided** |  | |
| **Financial details/Plan Manager** | | |
|  | ***Party responsible for payment MUST BE PROVIDED (include Participant number & Plan dates if NDIS or TAC funded), or formal approval of funding allocated if other organisation.*** | |
| **Name & Agency** |  | |
| **Address:** |  | |
| **Ph:** |  | |
| **Participant No. & Plan dates:** |  | |
| **Email:** |  | |
| **Administrator/Guardian (if applicable)** | | |
| **Name & Agency** |  | |
| **Address:** |  | |
| **Ph:** |  | |
| **Email:** |  | |
| **Other Services Involved** | | |
| **Name & Agency** |  | |
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