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| **Client Information** |
| Name |       |
| Address |       |
| Phone |       | State:       | Postcode:       |
| Date of Birth |       | Country of birth:        |
| Gender | [ ]  Male [ ]  Female [ ]  Other       | [ ]  Aboriginal/TSI |
| Language  |       | Interpreter required: [ ]  Yes [ ]  No |
| **Covid vaccination status:** Do you have a vaccination certification available? [ ]  Yes [ ]  No |

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| **Referrer Information**(Please include your Provider Number if you have one) |
| Name |       | Date of Referral |       |
| Role |       | Provider Number |       |
| Agency |       | Phone |       |
| Email |       | Mobile |       |
| Postal address |       |
| Reason for Referral |       |

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| **Type of service required** (tick all that apply. See Services page on our website for further explanation if needed) |
| [ ]  Behaviour Assessment | [ ]  Neuropsychology Assessment | [ ]  Behaviour Support Intervention | [ ]  Counselling |

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| **Funding Source** Please choose one and provide the following information: |
| **NDIS** | **TAC** | **Worksafe** | **DHHS/Corrections** | **Other**(medicolegal, medicare, private) |
| All question below need to answered before an NDIS funded referral can be considered.**NDIS Plan Number:**      **NDIS Plan Dates:**Start Date:      End Date:     **Managing Plan Funding:**(please tick one)[ ]  Self-Managed – please provide details of guardian (including email) for invoicing:      [ ]  Plan-Managed ­– please provide details of plan management agency (including email) for invoicing:      **Budget Line Items:** (tick all that are relevant)[ ]  Capacity Building - Improved Daily Living Skills Therapy Supports (15\_054\_0128\_1\_3)[ ]  Capacity Building - Improved Relationships Specialist Behaviour Intervention Support (11\_022\_0110\_7\_3)[ ]  Capacity Building - Improved Relationships Specialist Behaviour Intervention Support (11\_023\_0110\_7\_3)[ ]  Core - Assistance with Daily Life Therapy-related health supports (01\_701\_0128\_1\_3)**Please provide a copy of the plan, or excerpts of the plan relevant to neuropsychology services.** All the above questions need to be answered before the referral can be considered. | Please provide below the following information: **TAC Claim Number:**     **Date of accident:**     **Name of supportco-ordinator:**     **Contact phone number of support co-ordinator:**     **Email address of support co-ordinator:**       | Please provide below the following information:**WorkSafe claim number:**     **Date of accident:**     **Name of Worksafe agency:**     **Name of Worksafe claim manager:**     **Claim manager details:**Name:      Email:      A medical practitioner must provide a referral for psychology services prior to commencement of treatment. WorkSafe considers psychology tobe a referred service.**Referring medical practitioner details:** Name:      Phone:      Provider number:       | Please provide below the following information:**Name of DHHS support co-ordinator:**     **DHHS Branch Address:**     **Contact phone number of support co-ordinator:**     **Email address of support co-ordinator:**     **Invoicing details:**Name:      Postal Address:      Email:      **If more than one DHHS branch involved, please provide further details:**      | [ ]  Private Referral[ ]  Self Referral[ ]  Other[ ]  Request a Quote**Please provide funding details:**     **Invoicing details:**Name:      Postal Address:      Email:       |

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| **Please provide information where relevant:** |
| **Please describe main issues to be addressed**(e.g., capacity assessment, return to school, staff or family education, family relationship difficulties etc) |       |
| **Acquired Brain Injury**(If the person has ABI, please give details of date and cause of injury) |       |
| **Rehabilitation**(Please use the upload feature below to attach any relevant reports e.g., discharge summary, neuropsychology assessment) |       |
| **Other Medical History**(medical past or current medical issues of note, e.g., trauma, seizures, pain, blood pressure, diabetes, incontinence) |       |
| **Mental Health** |       |
| **Current Medications** |       |
| **Alcohol/other drug use** |       |
| **Behaviour**(e.g., verbal or physical aggression, socially or sexually inappropriate behaviour, wandering, absconding, lack of initiation) |       |
| **Cognition**(e.g., concentration, memory, planning, reasoning, insight) |       |
| **Communication Issues** |       |
| **Physical Issues** |       |
| **Sensory Issues**(e.g. hearing or visual impairment) |       |
| **Developmental issues**(e.g. complications during the pregnancy, birth or development) |       |
| **Any other issues that you think it is important for us to know?** |       |

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| **Previous Assessments** |
| **Type of Assessment** | **Date / Year** | **Name of organisation/assessor** |
| **1.**       |       |       |
| **2.**       |       |       |
| **3.**       |       |       |
| **4.**       |       |       |
| **5.**       |       |       |

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| **Legal** |
| **Legal Issues**(e.g. Youth Justice, Family Court, Child Protection) |       |
| **Restrictions on release of information:**(if applicable) |       |
| **Custody arrangements:** (if applicable) |       |

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| **Education** |
| **Adult** |
| **Education Level Completed:**       | **Best Subjects:**       | **Any Literacy/ Maths Difficulties:**       |
| **Child/Young Person** |
| **Type of institution**[ ]  Childcare[ ]  Kindergarten[ ]  Primary School[ ]  Secondary School[ ]  P-12 School[ ]  Specialist School[ ]  TAFE[ ]  Other (please specify):        | **Name of Institution**Name:      Address:      Postcode:      Phone:       | **Key contact person**Name:      Role:      Phone:      Email:       |
| **Has your child previously received any special assistance at school/kinder** (e.g. integration aide, reading program, ILP?) |       |
| **Particular issues/concerns relating to education at the moment:** |       |
| **Please describe your child’s strengths or interests:** |       |
| **If there any sensitive information that you would prefer not to discuss in front of your child, what is the best way for us to discuss this with you?** (e.g. by phone, separate meeting) |       |

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| **Work History** |
| **Previous Work History** |       |
| **Current Occupation** |       |
| **Current Interests and Hobbies** |       |

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| **Support Network**(Please give contact details where applicable) |
| **Name** | **Relationship with client** | **Phone** | **Email** |
| **1.**       |       |       |       |
| **2.**       |       |       |       |
| **3.**       |       |       |       |
| **4.**       |       |       |       |

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| **Important Family Members**(Please give contact details where applicable) |
| **Name** | **Relationship with client** | **Phone** | **Email** |
| **1.**       |       |       |       |
| **2.**       |       |       |       |
| **3.**       |       |       |       |
| **4.**       |       |       |       |

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| **Do any family members need an interpreter?** | [ ]  Yes [ ]  No |
| **Any issues related to family life that you would like us to be aware of?** |       |
| **Friends** |       |

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| **Service Providers**(Please give contact details) |
| **Case Manager** |       |
| **Physiotherapist** |       |
| **Recreation** |       |
| **Other Therapist** |       |
| **Guardian** |       |
| **Occupational Therapist** |       |
| **Speech Pathologist** |       |
| **Dietician** |       |
| **G.P.** |       |
| **Administrator** |       |
| **Others** (e.g., work and study contacts, attendant care agency, advocate, medical specialists etc) |       |

**Cancellation Policy**
Please note that we require at least 24-hours advance notice regarding cancellation of appointments, otherwise a cancellation fee may apply

**Please return this form and any relevant reports to:
Fax: 8678 3065**

**Email:** info@diverge.org.au