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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 support co-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](mailto:info@diverge.org.au)