Diverge
CONSULTING

Unit 204, 46 Graingers Rd, West Footscray, VIC, 3012
T: 9329 4330 F: 8678 3065 E: info@diverge.org.au W: www.diverge.org.au

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			

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			

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

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.

TAC

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:

Worksafe

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:

DHHS/Corrections

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:

Other
(medicolegal, medicare, private)

- ☐ 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	

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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?	

Previous Assessments

Type of Assessment	Date / Year	Name of organisation/assessor
1.		
2.		
3.		
4.		
5.		

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	Name of Institution	Key contact person
☐ Childcare ☐ Kindergarten ☐ Primary School ☐ Secondary School ☐ P-12 School ☐ Specialist School ☐ TAFE ☐ Other (please specify):	Name: Address: Postcode: Phone:	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	

Support Network

(Please give contact details where applicable)

Name	Relationship with client	Phone	Email
1.			
2.			
3.			
4.			

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	

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)	

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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:

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