



Please fill out the form below to begin the booking process for your client. To avoid delays, please ensure each section is filled in accurately. Please call our clinic on 9067 5607 if you require assistance. Email the form to office@brain-matters.com.au.

| ASSESSMENT REQUIRED (Please circle/highlight) | | | | |
|---|---|-------------------------------------|------------------------------|---------------------------------------|
| ADHD | Cognitive/Intellectual Developmental Disorder (IDD; inc. Adaptive Function) | Autism | Educational (inc. Cognitive) | Neuropsychology (inc. Cognitive) |
| Specific Learning Disorder (inc. Educational and Cognitive) | Medico-Legal Assessment (+ GST) | ADHD + Cognitive | ADHD + Autism | ADHD + Autism + Cognitive |
| ADHD + Autism + Cognitive | ADHD + Autism + Neuropsychology (inc. Cognitive) | ADHD + Educational (inc. Cognitive) | Autism + Cognitive | Autism + Educational (inc. Cognitive) |
| Autism + Neuropsychology (inc. Cognitive) | Educational + Neuropsychology (inc. Cognitive) | Other (please describe): | | |
| OTHER SERVICES REQUIRED | | | | |
| Adaptive Function (add-on) | Problem Solving Session | Therapy | Other (please describe): | |

| CLIENT DETAILS | |
|--|--|
| Client name: DOB (DD/MM/YYYY): Home Address (inc. Postcode): Mobile: Email: | Client's Emergency Contact Name: Mobile: Email: Relationship to client: |

| MEDICAL / PSYCHIATRIC HISTORY |
|--|
| Please add client's current diagnoses and relevant medical and psychiatric history |
| [add notes here] |

| REASON FOR TREATMENT / ASSESSMENT |
|---|
| What is the reason for this assessment/treatment how might it benefit the client? |
| [add notes here] |

| PERSON <u>LEGALLY</u> RESPONSIBLE FOR: | |
|---|--|
| <u>SIGNING DOCUMENTS:</u> Name: Mobile: Email: Relationship to client: | <u>BOOKING APPOINTMENTS:</u> Name: Mobile: Email: Relationship to client: |



| DETAILS OF PERSON MAKING THIS REFERRAL | |
|--|--|
| Name: | |
| Mobile: | |
| Email: | |
| Relationship to client: | |
| Organisation: | |
| Organisation Phone: | |
| Organisation Fax: | |

| GENERAL PRACTITIONER REFERRAL | |
|---|--|
| Does the client have a referral from their GP to receive our services? | |
| <input type="checkbox"/> YES (please ensure to send the GP's referral to office@brain-matters.com.au) | |
| <input type="checkbox"/> NO | |

| PAYMENT DETAILS | | | |
|--|-----------|------------------------|---------------------|
| Please indicate funder for this service | | | |
| Private | Medicare | NDIS Plan-Managed | NDIS Self-Managed |
| TAC | Workcover | Other Third-Party Body | Other (please add): |
| Please add more details below for the specific paying organisation (add N/A if the client is paying privately) | | | |
| Client's Reference Number: | | | |
| Organisation: | | | |
| Organisation Address: | | | |
| Organisation Email: | | | |
| Organisation Phone: | | | |
| Organisation Fax: | | | |
| <i>Please ensure to send the funding approval to office@brain-matters.com.au along with this referral. Emails that indicate the approval of funding will be accepted.</i> | | | |

| POSSIBLE COMPLEXITIES | |
|---|--|
| ADDITIONAL CHARGES: There are situations where a client's funding will exceed the original quoted amount for an assessment or therapy. This may include: | |
| <ul style="list-style-type: none">• Possible Additional Booking, Travel and Charges for Unforeseen Circumstances• No-show / Late cancellation fees | |
| Kindly specify the party responsible for covering any additional charges incurred to the client's financial account: | |
| <input type="checkbox"/> Client | |
| <input type="checkbox"/> Same as above ("PAYMENT DETAILS" section) | |
| <input type="checkbox"/> Other – Please add details below: | |
| <ul style="list-style-type: none">○ Paying Organisation:○ Org Name:○ Org location address:○ Org Email address:○ Org Tel:○ Org Fax: | |
| COURT ORDER | |



Is there an active court order pertaining to this client?

YES NO

IF YES:

does it require another person to sign client's agreement?

- Yes
- No

is the other person aware of the assessment and agrees for the assessment to go ahead?

- Yes
- No

Please provide their information:

- Name:**
- Mobile:**
- Email:**
- Relationship to client:**

DOES THE CLIENT REQUIRE WHEELCHAIR ACCESS

YES NO

INTERPRETER

Does the client or the person providing information for the client require an interpreter?

NO: YES (Please specify language):

IF YES:

Please note: Brain Matters is unable to organise interpreters. This is up to the client/organisation to set up. Please specify the person responsible for booking the interpreter:

- Name:**
- Mobile:**
- Email:**
- Relationship to client:**

BEHAVIOUR PROBLEMS

Are there risks associated with client's behaviour?

YES (please specify): _____ NO

DOES YOUR CLIENT REQUIRE A HOME VISIT

YES NO

IF YES please indicate any potential risks:

- Firearms
- Alcohol/drug abuse
- Pets
- Aggression
- Contagious Illness: _____
- Other: _____