Thank you for this referral. 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](mailto:office@brain-matters.com.au).

**ASSESSMENT TYPE(S)**

Please **circle/highlight** what type(s) of assessments or treatment the client requires (please note that you can select more than one:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Neuropsychology** | **ADHD** | **Autism** | **Intellectual Disability** | **Educational** |
| **Capacity** | **Specific Learning Disorder/Dyslexia** | **Therapy** |  | **Other: \_\_\_\_\_\_\_** |

|  |
| --- |
| **CLIENT INFORMATION** |
| **Client Name:**  **DOB (DD/MM/YYYY):**  **Home Address (inc. Postcode):**  **Best contact Mobile:**  **Best contact Email:** |
| **DIAGNOSES**  **Client’s current diagnosis and relevant medical and psychiatric history:** |
| **[Add notes here]** |
| **REASON FOR TREATMENT and/or ASSESSMENT**  **What is the reason for this treatment/assessment / how might it benefit the client:** |
| **[Add notes here]** |
| **PERSON LEGALLY RESPONSIBLE FOR SIGNING DOCUMENTS** |
| **Name:**  **DOB (DD/MM/YYYY):**  **Best contact Mobile:**  **Best contact Email:**  **Relationship to client:** |
| **PERSON RESPONSIBLE FOR BOOKING APPOINTMENTS** |
| **Name:**  **DOB (DD/MM/YYYY):**  **Best contact Mobile:**  **Best contact Email:**  **Relationship to client:** |
| **EMERGENCY CONTACT FOR THIS CLIENT** |
| **Name:**  **DOB (DD/MM/YYYY):**  **Best contact Mobile:**  **Best contact Email:**  **Relationship to client:** |
| **NAME OF THE PERSON MAKING THIS REFERRAL** |
| **Name:**  **Profession:**  **Best contact Mobile:**  **Best contact Email:**  **Relationship to client:**  **Organisation name:**  **Organisation phone:**  **Organisation fax:** |
| **GENERAL PRACTITIONER OF THE CLIENT** |
| **General Practitioner Name:**  **General Practitioner provider number:**  **Clinic Name:**  **Clinic Address:**  **Clinic phone:**  **Clinic fax:**  **Clinic email:**  **Has the General Practitioner referred this client to our serivces?:**   * Yes (I will send the referral letter to [office@brain-matters.com.au)](mailto:office@brain-matters.com.au) * No (I understand there will be a GST Charge for this assessment given that there is no GP referral) * Other (specify): |

|  |  |  |  |
| --- | --- | --- | --- |
|  | | | |
| **PAYMENT DETAILS** | | | |
| **Funder: Private/NDIS/TAC/Workcover/Other (please specify)** | | | |
| **If Private:** | **If NDIS:** | **If TAC or Workcover:** | **If Other:** |
| Brain Matters Reception will be in contact to obtain credit card details of client | **Client NDIS number:**  **Client Management:**   * Plan Managed * Self-Managed   **Client current Plan Dates:** DD/MM/YYYY **to** DD/MM/YYYY  **Paying Organisation:**  **Org Name:**  **Org location address:**  **Org Email address:**  **Org Tel:**  **Org Fax:** | **Client Claim Number:**  \*\* I will send the funding approval to [office@brain-matters.com.au](mailto:office@brain-matters.com.au) along with this referral\*\* | **Paying Organisation:**  **Org Name:**  **Org location address:**  **Org Email address:**  **Org Tel:**  **Org Fax:**  \*\* I will send the funding approval to [office@brain-matters.com.au](mailto:office@brain-matters.com.au) along with this referral\*\* |
|  |  |  |  |
| **IS THERE AN ACTIVE COURT ORDER PERTAINING TO THIS CLIENT? (Please circle/highlight)** | | | |
| **Yes** | | **No** | |
| 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:  **Their Name:**    **Best contact Mobile:**    **Best contact Email:**    **Relationship to client:** | |  | |
|  | |  | |
| **RISKS ASSOCIATED WITH HOME (please circle/highlight)** | | | |
| * None * Firearms * Alcohol/Drug Abuse * Pets * Aggression * COVID * Contagious Illness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
|  | | | |
| **DOES THE CLIENT REQUIRE WHEELCHAIR ACCESS (please circle/highlight)** | | | |
| * Yes * No | | | |
|  | | | |
| **HOW DID YOU LEARN ABOUT BRAIN MATTERS (please circle/highlight)** | | | |
| * Support Coordinator * Doctor * Hospital * Other Health Professional * Family/Friend * Signage * Social Media/Internet * Expo * Brochure * Vehicle * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |