arbias

ABI Specialist Services - Victoria

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arbias **Referral Form**	
COMPLETING THIS FORM: to place a cross in a box, double click the mouse in the box and select "checked".	
Date of referral:	
Services referring to:	☐ Neuropsychological Assessment **If making a referral to our other services, please call *arbias* Information, Linkages and Capacity Building (ILC) on (03) 8388 1222 to discuss eligibility *after* the neuropsychological report is finalised**
Has the person consented to this referral?	☐ Yes Date: ☐ No Please note the referral will not be accepted if the person does not consent.
NDIS details (only fill out if you are referring from NDIS package)	NDIS number: NDIS start and end date: Please circle funding source for 'Improved Daily Living' budget. Self-Managed Agency Managed Plan Managed If Plan Managed, please list: Agency: Contact number: Email:

Client Details			
Name (include alias if applicable)			
Address			
Post code		Gender	
Date of birth		Age	
Phone			
Is the person Aboriginal or Torres Strait Islander?	☐ Yes ☐ No		

Country of birth		Nationality	
Interpreter required?	☐ Yes ☐ No If Yes, please list what language or sign language:		
Describe the clients current living situation (type of accommodation, duration of residence, alone, with partner etc)			
Is there any support provided at current accommodation?	☐ Yes ☐ No If Yes, please provide details:		
Can the person read and write?	☐ Yes ☐ No	Comments	
Does the client have any social supports? (Friends, family members, case worker etc)			
Emergency Contact Details			
Name and relationship to client			
Address			
Phone			
Referrer Details			
Name and organisation			
Address			
Phone/Mobile		Fax	
Email			
Please outline your current role with the client:			
Details of ABI (Acquired Brain Injury)			

☐ Stroke ☐ Brain Infection ☐ Brain Tumour ☐ Traumatic (MVA/Falls) ☐ Assaults ☐ Alcohol related ☐ Other (please specify)	☐ Hypoxic (reduction of oxygen) ☐ Brain Surgery ☐ Epilepsy ☐ Suicide Attempts/ Blood Loss ☐ Professional fights ☐ Substance related
General Information	
Please state the client's current source of income:	
Is there a Legal Guardian or Administrator? Please provide name and contact details: **Please note for NPAIS referrals, Guardian MUST SIGN Referral declaration*	☐ Yes ☐ No
Employment/Education	Highest educational achievement (year level): Current occupation and duration: Previous employment history:
Psychosocial History	Please provide relevant information on the person's marital status, relationships, family etc
Recreational interests	
Legal status	☐ None ☐ Bond ☐ Parole ☐ CCO/CBO – Please attach a copy ☐ Child custody/ family dispute ☐ Other (please specify)

	Specify details of above:
Medical information Please list any current or past medical illnesses: Current medications:	
Please list any current or past psychiatric/mental illnesses: Current medications:	

Current and previous substance use *DO NOT COMPLETE THIS QUESTION if you are also completing in Appendix 1: arbias NPAIS referral form*	Please list substances Current use? Frequency of use? Interventions:
Is the client involved with the Department of Health and Human Services (DHHS)?	Please specify:
Is there a history of violence or sexual behaviours?	Please specify any risk factors:

Other Services Involved

Please list formal and informal supports involved:

Name of service	**Service type**	**Duration of involvement**	**Contact information**	**Consent to contact?**

MUST BE COMPLETED – Requirement of DHHS funding

Support Needs

How often does the client need personal HELP or SUPERVISION with ACTIVITIES or PARTICIPATION in the following life areas?

Life Areas	Unable to do OR always need help in the area	Sometimes needs help OR supervision in the area	Does not need help in this area but uses aides	Does not need help in this area and does not use aides
Self care	☐	☐	☐	☐
Mobility	☐	☐	☐	☐
Communication	☐	☐	☐	☐
Interpersonal interactions & relationships	☐	☐	☐	☐
Learning, applying knowledge and general tasks and demands	☐	☐	☐	☐
Education	☐	☐	☐	☐
Community (civic) & economic life	☐	☐	☐	☐
Domestic life	☐	☐	☐	☐
Working	☐	☐	☐	☐

Participation

To what extent does the person participate in the following life areas?

Life Areas	Fully	Partially	Not at all	Not known
Getting around outside	☐	☐	☐	☐
Using Transport	☐	☐	☐	☐
Maintaining family relationships	☐	☐	☐	☐
Maintaining social relationships	☐	☐	☐	☐
Recreation or leisure activities	☐	☐	☐	☐
Working	☐	☐	☐	☐
Handling money	☐	☐	☐	☐

Appendix:
Neuropsychological Assessment & Intervention Services (NPAIS)

COMPLETING THIS FORM: to place a cross in a box, double click the mouse in the box and select "checked"

If the referral relates to a **legal matter** (excluding guardianship and administration), please refer to the **Private Clinic Referral Form**.

Referral urgency: ☐ **HIGH** ☐ ROUTINE

Please note: **HIGH** urgency referrals must include a cover letter addressed to the NPAIS Manager outlining the urgency of the nature and urgency of the referral.

Referral Question Section Please answer **ALL** questions in this section	
Why are you referring the client for a neuropsychological assessment?	
What are the difficulties that the client is currently experiencing that you think may be related to possible brain impairment?	☐ Memory ☐ Attention/Concentration Problems ☐ Behavioral Concerns/Personality Changes ☐ Problem Solving ☐ Visual or Spatial Problems ☐ Other (please specify)
What areas of concern would you like addressed in the assessment report?	☐ Recommendations/strategies for informal and formal supports ☐ Access to services (housing, support agencies etc) Please specify: ☐ Administration order or Guardianship? Please specify: ☐ Other Please specify:

Is the report going to be used for a particular purpose?	☐ VCAT – Is there a hearing date set? Date: ☐ Access to support services ☐ Target Group Assessment (for disability funded services) ☐ Behavioral support (e.g. Case Management, participation in community programs etc) ☐ Community Corrections Order (CCO) ☐ Other (please specify)
Are there any risks to the neuropsychologist? (Physical aggression, triggers)	Please specify:

Alcohol and Other Drug (AOD) History (complete only if applicable)

Please provide details in the table below: *E.g. Alcohol, cannabis, amphetamines (e.g. speed, ice,), opiates (e.g. heroin, morphine), cocaine, ecstasy, GHB, hallucinogens (e.g. LSD), benzodiazepines (e.g. Valium, Xanax), inhalant's (e.g. paint, glue, petrol), or any other substance.*

Substance of choice:

Substance				
Age first used				
Age of first regular use				
When last taken				
Total length of heavy use (months/years)				
Overdoses or loss of consciousness? **How often?** **How long?**				

Has the client had any of the following?	☐ Neuropsychological/Cognitive Assessments ☐ Brain Imaging (CT or MRI) ☐ Psychological/Psychiatric Assessment or admissions ☐ Alcohol or Substance detoxification/Rehabilitation **Please provide details and attach any relevant reports/ documentation**

Referrer Checklist	
Please complete before submitted referral form	
Have all questions in the Referral Question Section answered?	☐ Yes ☐ No
Have you attached any supporting documents to the application?	Please specify:
Have you sent the medical information page (overleaf) to the client's GP?	☐ Yes ☐ No

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Medical Information	
Referrer - *Please fill in client's name & date of birth details and then fax or email this form to the clients GP for completion*	
Dear Dr, The following client has been referred to arbias for a neuropsychological assessment. **Client name**: ..... **Date of Birth:** ..... Please complete the section below or attach a Patient medical Summary This information will provide important background information in anticipation of their neuropsychological assessment.	
GP Name & Address	
Medical History *Current medications*	
Is there a history of brain impairment or injury? (Duration of coma/PTA, hospitals attended)	*Please specify*
Previous investigations (CT, MRI Scans)	*Please specify*
Please specify any other relevant details	
GP Signature	
Date	

Return Completed Form to; arbias – Intake
FAX (03) 9387 9925 Email: intake@arbias.com.au