Health
South Eastern Sydney
Local Health District

Facility: Adahps

REFERRAL FOR NEUROPSYCHOLOGICAL ASSESSMENT

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION / WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Date of Referral:

CLIENT DETAILS

Gender at Birth:

Country of Birth:	Phone
Preferred language	Interpreter required? ☐ Yes ☐ No

Aboriginal and/or Torres Strait Islander origin? ☐ Yes ☐ No ☐ Decline to respond ☐ Unknown

If yes → ☐ Aboriginal origin ☐ Torres Strait Islander origin ☐ Both

Medicare Number:	Valid to:

REFERRER DETAILS

Name:	Organisation:
Address:	
State Postcode	Phone
Email:	

REASON FOR REFERRAL/HISTORY OF COGNITIVE PROBLEMS

GUARDIANSHIP / FINANCIAL MANAGEMENT

Indicate whether Guardianship or Financial Management Orders are being sought

HIV HISTORY

Date of Diagnosis:

Past opportunistic infections (and dates if known):

Most recent CD4 count and viral load (Provide a copy of pathology results if possible)

Nadir (lowest ever) CD4 count and date

Current medications and how long have been prescribed

Past CT/MRI brain scans (Provide a copy of pathology results if possible)

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OTHER RELEVANT MEDICAL HISTORY

Neurological:

Psychiatric:

Drug & Alcohol:

Co-morbid conditions (e.g. Hepatitis C):

Other:

OTHER RELEVANT INFORMATION

Anything else you consider relevant?

WORK HEALTH & SAFETY

The referrer should locate a suitable room for conducting the assessment.

Neuropsychological assessments will not be conducted in people's homes.

Are you aware of any safety concerns in seeing this client?

Will the assessment take place in a safe health facility?

Will there be other staff nearby?

Is the furniture in the room arranged/able to be arranged so that clinician seating is closest to the door?

NO WRITING