REFERRAL FORM

Assessment Services

Ability Assessment Solutions

Referral Information:

Name & DOB:

Phone & Email:

Client Address:

Parent / Guardian (if applicable, incl. POA)

Referral For Assessment Of:

- ☐ Cognitive Function
- ☐ Functional / Adaptive Behaviour
- ☐ Learning / Achievement
- ☐ Autism Spectrum Disorder
- ☐ Attention Deficit/Hyperactivity Disorder Traits (ADHD)
- ☐ Other (details below)

Referral Goal

- ☐ NDIS Eligibility / Access
- ☐ DSP Eligibility / Access
- ☐ Access or Funding Related (details below)
- ☐ Diagnostic Queries
- ☐ Court or Legal Matters
- ☐ Other (details below)

Please Specify Referral Information & Other Questions or Comments

Referral Questions & Terms:	YES	NO
I am aware that I will be contacted to discuss this referral further and have provided my contact information.	☐	☐
I confirm that the Client is aware of and consenting to the referral, and may be contacted.	☐	☐
Are past reports, documentation or other relevant medical history available for review? Please attach to referral, or forward through when otherwise available.	☐	☐
Does the Client have a current treating health team (e.g. Psychologist, Psychiatrist, ACT / PHN engagement or similar?). Please provide relevant details above.	☐	☐
I am aware that referrals are reviewed by the relevant Intake Team and may not progress, as informed by determinations regarding the suitability and availability of services. Accordingly, I am aware that a referral does not constitute the commencement of support, or an agreement to enter into an episode of care, and thus retain independent duty of care of the client. I am aware that incorrect or insufficient referral information may limit it's progression in the Intake process. Finally, that if a referral cannot be progressed for whatever reason (e.g., if we are unable to contact the referring party and/or client), the referral will be automatically closed with no further action.	☐	☐

Referrer Name:

Signature & Date:

Phone Number & Best Days / Times To Contact You: