REFERRAL FORM

Psychology & Assessment Services

Student Referral (Third Party Provider Use Only)

Student Information

Student Name

Referrer Details

D.O.B.

Date

Referral For

- ☐ Cognitive Assessment & Report
- ☐ Functional Assessment & Report
- ☐ General Support / Psycholgy Sessions
- ☐ Autism Assessment & Report
- ☐ Cognitive & Learning Assessment
- ☐ To Be Determined

Referral Goal

- ☐ NDIS Eligibility / Access
- ☐ DSP Eligibility / Access
- ☐ General Support / Psycholgy Sessions
- ☐ Diagnostic Queries
- ☐ To Support Learning
- ☐ Other (please specify)

Relevant Background Information / Other Comments

Questions :

Would you like to request a consultation in advance of assessment?	☐ Yes	☐ No
Does the student have a current treating health team (e.g. Psychologist, Psychiatrist, CYMHS engagement or similar?)	☐ Yes	☐ No
Is the student (and Guardian if <18 years) aware of and consenting to referral?	☐ Yes	☐ No
Are past reports, documentation or other relevant medical history available for review? Please attach to referral, or forward through when otherwise available.	☐ Yes	☐ N/A