MINDSIGHT CLINIC

REFERRAL FOR NEUROPSYCHOLOGICAL SERVICES

REFERRING CLINICIAN

Name | Provider Number

Address | Email

Phone (02) | Fax (02)

Signature | Date

PATIENT DETAILS

Title/First name | Last name | DOB

Street Address | Suburb | Postcode

Medicare Number _/_ Exp _'24 | Gender ☐ M ☐ F

☐ DVA ☐ Workcover | Preferred language ☐ English ☐ Other (specify):

Preferred method of contact (Complete if your patient consents to our reception team contacting them directly to book an appointment)

☐ Mobile | ☐ Email

Alternative contact (Complete if there is someone our reception team can contact if we are unable to reach the patient)

Name | Relationship | Phone number

Current General Practitioner (if not the referring doctor)

Name | Practice

REFERRAL DETAILS

REFERRAL PURPOSE/QUESTION (tick all that apply)

- ☐ Baseline cognitive testing
- ☐ Diagnostic clarification (eg dementia, ID)
- ☐ Monitoring Cognitive Function (pre/post treatment cognitive functioning)
- ☐ Functional impact/assessment (eg driving, independent living, capacity)
- ☐ Patient/carer/family psychoeducation
- ☐ Cognitive Rehabilitation and remediation including CogMed working memory training

BRIEF CLINICAL HISTORY

Please include description of neuropsychological difficulties (memory, concentration, communication, visuo-spatial, executive, behaviour, personality change) or functional difficulties (work, study, driving, independent living, relationships, safety concerns)

PREVIOUS COGNITIVE/NEUROPSYCHOLOGICAL TESTING *Screen type, score and date of assessment e.g. MMSE MOCA ACE results. Have they had a neuropsychological assessment before? When?*

OTHER RELEVANT HISTORY *Drug and alcohol history, other medical conditions, family history*

Please fax referral and any other relevant documents to (02) 9157 9022 or email to info@mindsightclinic.com.au