Updated 01/04/2022

**REFERRAL TO THE NEUROSCIENCES UNIT PAEDIATRIC DIAGNOSTIC TEAM**

***Confidential*** *– Please print clearly*

|  |
| --- |
| **REFERRER’S DETAILS:** |
| Referrer: | Position/Title: | Telephone: |
| Agency: | Email: |
| Address: |
| **CLIENT’S DETAILS:** |
| Client’s Name: |
| Date of Birth: | UMRN (if known): |
| Is child known by any other name? | Gender: |
| Home Address: |
| Current School: | Year Level: |
| Language Other Than English: |  | Interpreter Required? | Y / N |
| Aboriginal or Torres Strait Islander: | Y / N |
| **RELEVANT FAMILY INFORMATION** |
| * Nuclear Family
 | * Single Parent
 | * Blended Family
 | * CPFS Involvement
 |
| Legal Guardian: | Best Contact Person: | Relationship to child: |
| Home Phone: | Mobile: | Email: |
| Language Other Than English: | Interpreter Required? | Y / N |
| Family aware of referral? | Y / N | **Note**: Attached consent form signed by parent/guardian authorised to give consent MUST be included with the referral |
| Additional information: |
| **RELEVANT NEUROLOGICAL/MEDICAL/PSYCHOLOGICAL HISTORY:** |
|  |
| **RELEVANT SPEECH AND LANGUAGE HISTORY*:*** |
|  |

|  |
| --- |
|  |
| **REASON FOR REFERRAL AND GOALS FOR THE ASSESSMENT(S):***Please make referral questions as specific as possible.* |
| Referral stream (please note that additional referral criteria apply for FASD). See list of Records and Reports required to support referral listed below:* General assessment queries ☐ FASD assessment (referral from paediatrician only)
 |
|  |
| **RECORDS AND REPORTS REQUIRED:***The following records are to be included in the referral*. |
| **For all Referrals:*** Copy of recent clinic letter (if referrer is from a medical provider)
* Copy of any previous neuropsychology, school psychology, or other cognitive testing reports (if available)
* Copy of any speech and language testing reports reports (if available)
* Copy of EEG/Neuroimaging reports not on IMPAX; results of genetic tests/sleep studies, etc.
 |
| **Additional records for Foetal Alcohol Spectrum Disorder Assessments (FASD):*** Evidence of alcohol exposure in utero (in concordance with the Australian Guide to the diagnosis of FASD). If possible, complete and attach a copy of the Audit C tool for details of alcohol exposure in utero.

Source of PAE report:* + Biological mother
	+ Immediate family. Specify whom: First-hand witness: Y / N
	+ Foster carer. Specify whom: \_ First-hand witness: Y / N
	+ CPFS. Please note if formally documented: Y / N
	+ Police / Birth / Other Hospital records (please circle)
* Results from an assessment of sentinel facial features if completed OR a referral for facial photography has been made.
 |
| Are you aware of any psycho-emotional or behavioural factors that may affect a lengthy testing session? *(e.g. anxiety, agitation, aggressive behaviours, physical limitations etc.)* | Y / N |
| Do you believe the child will be comfortable separating from his/her parents/carers during the assessment (*3 - 4 hours*)? | Y / N |
| Are there any outstanding medico-legal or other legal/family court issues? | Y / N |
| If yes to any of the above, please specify: |
| Current medication (*include* dose *and* length *of use*): |

Please include all requested documents in referral including Consent Form (on next page) as signed by parent/guardian. Note waitlists apply.

To discuss the suitability of this referral, please phone the Duty Clinician on (08) 6159 6464.

|  |  |  |  |
| --- | --- | --- | --- |
| Signed by Referrer: |  | Date: |  |
| Consultant Details (if appropriate) |  |

Referrals can be emailed to Graylands.Neurosciences@health.wa.gov.au (preferred) or faxed to 08 9385 6813.

|  |  |
| --- | --- |
| **NEUROSCIENCES UNIT****Consent Form** | Med Rec. No: ………………………………………………..Surname: …………………………………………………….Forename: ……………………………………………………Sex: …………..……….. D.O.B. …………………………… |
| **AUTHORISATION TO RELEASE AND EXCHANGE INFORMATION** |
| I, Of *(address)* Hereby, authorise professional staff employed at the Neurosciences Unit to release / obtain / exchange information (written and verbal) with other agencies and individuals in relation to*(Client’s name) (DOB:)* Please tick one box below:* Yes, I consent to the release of information to agencies/people ticked below
* No, I do not consent to the release of any information
* Can I discuss with a Health Professional?

in relation to *(specify nature of information)* I understand this information concerns personal affairs and is considered confidential. This authority expires one year from the date upon which it is signed.Patient Signature: Date: Parent/Guardian Signature: Date: Relationship to Patient:  |

|  |  |
| --- | --- |
| **Agency/Service Provider/Individual** *(Must**specify name of service/provider in next column)* | **Specific details of service/provider and/or****conditions of consent if required** |
| * Referring Service
 |  |
| * Paediatrician or other specialty medical provider
 |  |
| * General Practitioner (GP)
 |  |
| * School including teaching staff, principal,

deputy principal and School Psychologist unless otherwise specified |  |
| * Psychologist/Mental Health Provider
 |  |
| * NDIS/Therapy Providers
 |  |
| * Other individuals (i.e. – other carers who may bring child to appointment, case managers, support workers, etc.)
 |  |

|  |  |
| --- | --- |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

|  |  |
| --- | --- |
| **NEUROSCIENCES UNIT****Consent Form** | Med Rec. No: ………………………………………………..Surname: …………………………………………………….Forename: ……………………………………………………Sex: …………..……….. D.O.B. …………………………… |
| **CONSENT TO CONTACT FOR CONSUMER/CARER ACTIVITIES** |
| The Neurosciences Unit is committed to involving consumers and carers in the design of service provision. Your input is highly valued and vital to improving our service, therefore we ask you to give us permission to contact you at some time in the future to invite you to take part in consumer/carer participation activities. These activities may be about being involved in a ‘Consumer Advisory Group’, contributing in focus groups or forums, or being a consumer representative. Your consent to contact can be withdrawn at any time. The Neurosciences Unit represents the rights of the patients under the Confidentiality Act.I, *Parent (Mother/Father) / Guardian / Patient over 16 years (please circle)*Of *(address)* Hereby agree that I and (patient name) , may be contacted in the future.I understand that either the parent/carer, or patient named above, can withdraw permission at any time or verbally when contacted.**Carer / Parent**Signature: Date: \_ Home Phone: Mobile: Email: **Patient (Over 16)**Signature: Date: Home Phone: Mobile: \_ Email:  |
|  |
| **CONSENT FOR ASSESSMENT** |
| I (parent/guardian), \_ consent to my child, being assessed by the staff at the Neurosciences Unit and understand that the assessment and subsequent treatment plan (Individual Service Plan) / outcome of assessment will be discussed with me.Signed By Parent / guardian : Signed By Witness: Date: Date:  |

**NSU – CONSENT FORM (Page 2)**