FedCare Psychology Services
Suite 4, Greenhill Enterprise Centre
Mt Helen Campus, Tach Park
28 University Drive, Ballarat
Phone: 03 5327 8483

ORGANISATION REFERRAL FORM

Date of referral:	
Referred by (print name):	
Organisation:	
Telephone:	
Email:	
Is the client aware of referral?	❑ Yes ❑ No

CLIENT DETAILS

First name (s): _____

Last name: _____

Address: _____

_____

Date of birth: _____ Email: _____

Phone: _____ Mobile: _____

REASON FOR REFERRAL:

Assessment ☐ Treatment/therapy ☐

If referred for assessment, please select your concerns:

☐ Specific concerns about **learning** in one or more areas (select all that apply)

☐ Reading ☐ Writing ☐ Maths ☐ Spelling

Please state academic intervention provided, i.e. names of specific programs the person has completed and length of time they have engaged in this.

_____

_____

NOTE: If intervention has not yet occurred for the area/s of concern, a formal diagnosis cannot be made. A provisional diagnosis MAY be made; however, this may impact the person's eligibility for funding. To qualify for a formal diagnosis, the person must have engaged in 6 months of evidence-based intervention in the area of concern and shown no considerable improvement.

☐ General/broad concerns about cognitive functioning (i.e. suspected Intellectual Disability)
Are you aware of previous cognitive assessments being done? Please state date, name of test and result if known:

_____

_____

☐ Clarifying the person's strengths and weaknesses
☐ Suspected ADHD
☐ Suspected autism
☐ Other

_____

_____

NOTE: FedCare Psychology Services cannot complete autism assessments. Screening can be done to indicate whether further assessment is necessary.

Please provide additional information about your reason for referring this person:

_____

_____

_____

_____

_____

_____ ____/____/____ _____ ____/____/____
Signature (referring person) *Date* *Signature (client)* *Date*