

The Turning Point Addiction Neuropsychology Service can assist adult clients with two types of referrals:

1. Diagnostic question

The referral question is specifically to know whether a client has an acquired brain injury (ABI) or other brain disorder. This is often required to support an application to NDIS or DSP.

We cannot complete an ABI assessment for NDIS or DSP when the client is currently using substances thought to influence their cognition.

2. Guiding support and management

We help people to understand a client's difficulties relating to thinking skills, behaviour, and emotions.

This can help clients engage in life activities such as working, socialising, and hobbies. It may increase attendance at support groups or strengthen therapeutic alliance.

The referral question is around possible contributing factors to cognitive impairment, ways the referrer might be able to address these, or ways that a referrer can work more meaningfully with a client.

Referrals must meet all of the below criteria:

- ☐ **Subjective concerns** (thinking difficulties and/or behaviour regulation challenges) noticed by you or reported by the client.
- ☐ **Regular substance use** (current or past).
- ☐ **Client consents** to the referral (signature required, see page 8).
- ☐ You (referrer) will have **ongoing engagement** with the client, and can implement treatment recommendations and strategies we suggest.
- ☐ The client is **not in an acute crisis** (e.g. active psychotic symptoms, acute risk suicide or homicide).

Please note we do not conduct assessments for capacity (VCAT, parenting); medico-legal referrals; or referrals where the primary referral question is for diagnosis of ADHD or autism spectrum disorder.

Please provide completed form and any attachments to via email or fax:

Email: neuropsychologyclinic@turningpoint.org.au

Fax: 03 8413 8499

Contact us on 8413 8413 for any queries

We ask that you help clients to fill in details on this referral form reflecting on their thinking skills (orange section, pages 6- 7).

If your client is unable to complete this section due to their impairments, you can still make a referral.



Referral process



For most referrals the recommendations provided during the secondary consult can address raised concerns without the need for a full assessment.

Client details

Name

Date of birth (DD/MM/YYYY)

Address including postcode

Contact number

Gender

Pronouns

Aboriginal and/or Torres Strait Islander?

Identify as LGBTIQA+?

Interpreter required? What language?

Years resided in Australia? (If not born in Australia)

Referrer details

Referrer name

Role

Organisation

How long have you known the client?

Phone number

Email

Postal address

Reason for referral

What is your reason for referral? (refer to page 1). What are you hoping to achieve from this referral?

What are your subjective cognitive or behavioural concerns about the client? What are the client's concerns? When did the concerns start? Have they improved, fluctuated or worsened over time?

Are you seeking a diagnosis for NDIS/DSP or other funded services? What diagnosis are you seeking?
We cannot complete an ABI assessment for NDIS or DSP when the client is currently using substances thought to influence their cognition.

Support network

GP Name

GP Practice

GP Address

Other supports – please include name, position and phone number. (e.g. psychiatrist, case manager, care and recovery co-ordinator, AOD worker, NDIS co-ordinator, corrections officer).

Psychosocial history

Describe client's current relationships, housing, occupational status.

Legal status/offending history including incarcerations and active intervention orders.

Developmental history

Highest level of education completed.

Ever suspended or expelled from school?

Was your client ever diagnosed with, or suspected of having a developmental condition such as ADHD, autism, intellectual disability or a learning disability such as dyslexia? Please provide details.

Did the client ever receive aid support or interventions at school (e.g. reading recovery)?

Is there any known maternal use of alcohol or other drugs when she was pregnant with the client?
Parental smoking when pregnant or when your client was an infant?

Any knowledge of low birth weight, premature birth, or needing intervention in hospital?

Mental health

Are you aware of any trauma history, please indicate the following: childhood, adulthood; whether the trauma is physical, sexual, emotional; experienced or witnessed.

Known or suspected mental health diagnoses, please indicate year of diagnosis and who diagnosed.

Any current or past indicator of risk to self or others (suicide, homicide, family violence).

Any current symptoms of psychosis (paranoia, delusions, hallucinations).

Alcohol and substance use

What is the client's **primary substance of concern**?

Substance use

Please include illicit use of prescribed substances, e.g., using Seroquel, Valium recreationally.

	Age first tried	Age daily use	Duration of daily use	Average daily use (g / ml)	Days used in last month	Days since last use
Alcohol						
Cannabis						
Amphetamines						
Methamphetamine						
Heroin						
Inhalants Type:						
GHB						
Benzodiazepines or other Z drugs						
Antipsychotic or antiepileptic*						
Opioids						
Other:						
Other:						
Other:						

Examples

***Antipsychotic/antiepileptic: Seroquel, risperidone, lyrica, sodium valproate.**

Amphetamines: speed, or prescribed amphetamines including dexamphetamine, vyvanse, methylphenidate.

Inhalants: nitrous oxide (whippets), spray paint, petrol, glue, paint thinner, amyl.

Benzodiazepine and Z drugs: valium, xanax, zopiclone

Hallucinogens: acid/lsd, magic mushrooms/psilocybin, DMT.

Opioids: oxycodone, tramadol.

Other prescribed: Modafinil, Stillnox.

MDMA/party drugs.

Cocaine.

Medical History

Current medications (including pharmacotherapy)

Medication	Dose	Frequency (e.g. 2 daily or as needed)	Duration prescribed	Does client miss needed doses?

Medical events

	Period of loss of consciousness	Duration of hospitalisation (if applicable)	What hospital?	When did this occur?	Any other information?
Vehicle Accident					
Assault(s)					
Accidents/falls					
Suicide attempts					
Overdose					
Stroke					
Heart attack					

Any other significant medical history? (e.g. chronic pain; liver disease; autoimmune disorders; COPD; diabetes; malnutrition; presence of blood borne viruses, e.g. Hep C etc)

Is there any other information that is important for us to know?

Client Section – client to fill in the orange section with help from referrer

What is a neuropsychological consultation?

You may be having difficulties with memory, thinking skills, emotions or behaviour. Your support worker would like to consult with a clinical neuropsychologist at Turning Point to discuss helpful strategies to better support you.

- With your permission, your support worker will provide the following information to the neuropsychologist: your background information, previous assessment report(s) if available
- Your support worker will make time to speak to the neuropsychologist. You won't need to attend any face-to-face appointments at this stage.
- Your worker will let you know the outcome and will discuss any recommendations made.
- In some cases, a face to face neuropsychological assessment will be recommended. This will be discussed with you.

Privacy and Confidentiality

All personal information gathered by the neuropsychologist will remain confidential and secure, except when:

1. It is subpoenaed by a court; or
2. Failure to disclose the information would place you or another person at serious risk to life, health or safety; or
3. Your prior approval has been obtained to provide a written report to another professional or agency, or discuss the material with another person; or
4. Disclosure is otherwise required by law.

Access to client information

You are entitled to access your personal information kept on file, subject to exceptions in the relevant legislation. Turning Point may discuss with you different possible forms of access.

Client consent to referral

- ☐ I have read and understood this consent form.
- ☐ I agree for the above conditions for the neuropsychology service provided by Turning Point.

Quality control and research

Do you agree for your de-identified data to be used in quality control/research by the Turning Point Addiction Neuropsychology Service?

- ☐ Yes
- ☐ No

Please note: Your decision about whether or not to consent to quality control and research will not affect the quality or type of any services that you receive from Turning Point. You can withdraw consent for quality control and research at any time.

Signature of client consenting

Name of client consenting

Date

Client Section – client to fill in the orange section with help from referrer

Check the box that best describes how you have felt and conducted yourself over the past 6 months.

1. How often do you have difficulty concentrating on what people are saying to you even when they are speaking to you directly?
2. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?
3. How often do you have difficulty unwinding and relaxing when you have time to yourself?
4. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to before they can finish them themselves?
5. How often do you put things off until the last minute?
6. How often do you depend on others to keep your life in order and attention to details?

Never	Rarely	Sometimes	Often	Very Often

Is there any other information that is important for us to know?

Thank-you for your responses. We will use these to help understand you, so that we can make informed recommendations to support your thinking skills.