PSYCHO-PHYSIOLOGICAL ASSESSMENT REFERRAL FORM

neuroCare

Referrer details

Name

Location

Contact No.

Email

Patient details

Name

D.O.B.

Parent's Name*

where relevant

Contact No.

Suspected concerns for assessment

- Sleep Difficulties / Disorders ☐
- Mood/ Depression ☐
- Anxiety (incl. OCD symptoms) ☐
- ADHD / ADD ☐
- Learning Difficulties / Dyslexia ☐
- Speech & Language Delay ☐
- Performance Difficulties (Work / Sport) ☐
- Post-Natal Psychological Difficulties ☐
- Other (please specify)

This patient requires the following assessment

- QEEG (Quantitative EEG) Assessment ☐
- Sleep Assessment (Actigraphy) ☐
- Neuropsych Assessment ☐
- Cognitive & Educational Assessment ☐
- ADHD Assessment ☐
- Auditory Processing Assessment ☐
- Psychological Mental Health Assessment ☐

Pre- Assessment (if completed)

Most recent K10* score

Date of Score

Kessler Psychological Distress Scale (K10)

Further Notes

Please mention any relevant, current and past health information (incl. medication, head injuries, other related difficulties)

Referrer's Signature

Referral Date

Please print or save this digitally completed form and send to the patient's preferred neuroCare location.

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