neuroCare Sydney - Level 19, 56 Pitt St

REFERRAL FORM

Referrer Details

Name _____ Provider No. _____

Contact No. _____ Fax No. _____

Practice Name & Address _____

Email _____

Patient Details

Name _____ D.O.B _____

Parent/Guardian _____ Contact No. _____

Email _____

Suspected Concerns for Assessment

- Sleep Difficulties / Disorders ☐
- Mood / Depression ☐
- Anxiety (incl. OCD symptoms) ☐
- ADHD/ ADD ☐
- Learning Difficulties / Dyslexia ☐
- Performance Difficulties (Work / Sport) ☐
- Other (please specify)_____

Query Suitability for Treatment

Psychotherapy / Psychiatry Services ☐

Individual (child, adolescent, adult) couples and families

TMS (Transcranial Magnetic Stimulation) ☐

Suitable therapy for Depression or OCD. Therapy duration (on average) 20 - 30 sessions total, 2 x sessions weekly minimum

Neurofeedback (QEEG-informed) ☐

Suitable therapy for ADHD, Sleep Problems, Cognitive Performance Problems. Therapy duration (on average) 30 - 40 sessions total, 2 x sessions weekly minimum

Auditory Training Program ☐

Suitable therapy for Dyslexia, Auditory Processing Difficulties, Speech & Language Delay/Difficulties. Minimum 20 hours, sessions held daily, may be integrated with other learning / development programs

Further notes

Please mention any further relevant, current and past health information (incl. medication, major illness, head injuries)

Please select the practitioner you are referring to

Psychiatrists

☐ **Dr Mark Ryan**

please attach **cover letter for patient Medicare claiming purposes*

Psychologists

☐ **Erica Chow**

please attach **Mental Health Care Plan for patient Medicare claiming purposes*

Referrer's Signature _____ **Referreral Date** _____

You can send this completed referral to **sydney@neurocaregroup.com** or by Fax to **(02) 8038 6334**