Hunter PR1MARYCARE

Psychological Assessments Referral Form

If you are submitting this referral on behalf of someone aged 16 years and over, please indicate below if it has been discussed with that person, and if that person has consented to the referral.			
Has this referral been discussed with the person?		☐ Yes ☐ No	
Has the person consented to this referral?		☐ Yes ☐ No	
Client Name		**Date of Birth**	
Name of parent/caregiver (if under 18)			
Address			
Contact number		**Preferred contact method**	☐ Phone ☐ Email
Email			
Does the person identify as Aboriginal or Torres Strait Islander?	☐ Neither Aboriginal nor Torres Strait Islander ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Both Aboriginal and Torres Strait Islander		
Gender			
Pronouns	☐ He/Him ☐ She/Her ☐ They/Them ☐ Other (Please specify)		
Assessment Type	☐ Autism Assessment ☐ ADHD Assessment ☐ Adult/Adolescent ADHD Assessment ☐ Combined Autism/ADHD Assessment ☐ Learning Assessment		
Assessment Goals	**Please provide some information about what you are hoping to obtain from this assessment. For example, getting an idea about possible strengths and difficulties for an individual? Are you hoping this assessment might support additional funding applications?** ☐ Confirm or rule out ASD, ADHD, or cognitive impairments. ☐ Understand cognitive abilities such as memory, attention, and problem-solving. ☐ Guide interventions or individualised education plans. ☐ Understand behavioural or emotional challenges related to ASD, ADHD, or cognitive issues. ☐ Support applications for access to services or funding (e.g., NDIS). ☐ Identify any related conditions like anxiety or learning difficulties. ☐ Help with planning for life transitions (e.g., school to adulthood). ☐ Track changes in cognitive function or behaviour. ☐ Inform strategies for treatment or behavioural management. ☐ Address social communication challenges, particularly for ASD.		
Additional Information			

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Risk	**Is the client currently experiencing any of the following?** (Check all that apply): ☐ Expressing thoughts of self-harm or suicide ☐ Engaging in self-harm behaviors ☐ Showing aggressive or harmful behavior towards others ☐ Experiencing severe anxiety or panic attacks ☐ Having frequent emotional outbursts (e.g., extreme anger, frustration, or sadness) ☐ Becoming very socially withdrawn or isolated ☐ None of the above		
Referrer Details			
Name		**Contact number**	
Role/Relationship			
How did you hear about our service?	☐ Health professional ☐ Family member/friend ☐ Hunter Primary Care staff ☐ School ☐ Service provider ☐ Social media ☐ Google search ☐ Other – please specify:		
GP Details *(if not referrer)*			
GP Name			
GP Practice			

Please send this completed referral form via email to MHIntake@hunterprimarycare.com.au.