REFERRAL FOR STUDENT PSYCHOLOGICAL ASSESSMENT

***CONFIDENTIAL***

**Student Details** Male: 🞏 Female: 🞏

Family Name: ………………………………….. Given Names: …………………………………………….....

Date of Birth: ………………………………….

School: ………...………………………..…….. Grade: …….. Teacher: ……………………………………

## Parent/Guardian 1

Family Name: …………………………………...Given Names: ……………………………………………….

Relationship to student: ………………………………………………………………………………………..

Phone: Home:……………....….…… Work: :………………..………… Mobile : ……………...…………………

Home Address: …………………………………………………………………………………………………

Suburb: …………………………………………………………………….. Postcode: ……………………….

Email: ……………………………………………………………………………………………………………

## Parent/Guardian 2

Family Name: …………………………………...Given Names: ……………………………………………….

Relationship to student: ………………………………………………………………………………………..

Phone: Home:……………....….…… Work: :………………..………… Mobile : ……………...…………………

Home Address: …………………………………………………………………………………………………

Suburb: …………………………………………………………………….. Postcode: ……………………….

Email: ……………………………………………………………………………………………………………

**Siblings** Names (if relevant)

**Person Initiating Referral: ……………..…………..… Relationship to Student: ……………………**

**Date of Referral: …………….………..**

**Parents/guardian has signed *Consent Form for Psychological Assessment*** *(page 3)*

Date referral and consent forms received by Launceston Therapy Clinic  **PTO**

## REFERRAL INFORMATION

1. **What are the presenting concerns?**
2. **Background information:**  Diagnosed medical information  relevant family information  previous assessment information  vision checked  hearing checked

other. Please provide details.

1. **What strategies have been, or are being used?** E.g., Include specific adjustments to curriculum areas and learning programs within and outside the classroom, such as speech/teacher aide time, visual timetables, behaviour management, and literacy and numeracy support.
2. **What type of assessment are you looking for?** (please tick all that apply)

🞏 Cognitive assessment only (e.g. *WISC-V*)

🞏 Cognitive and academic assessment (e.g. *WISC-V and WIAT-III*)

🞏 Adaptive Functioning Skills

🞏 Social-Emotional-Behavioural Assessment

🞏 Other (please specify): ………………………………………….

1. **What outcomes do you expect from this referral?**
2. **Who is, or has been involved with the student?** E.g.,Specialist support staff inside or outside the school, other service providers such as medical or allied health practitioners, or other community agencies.

CONSENT FORM FOR STUDENT PSYCHOLOGICAL ASSESSMENT

***CONFIDENTIAL***

**Student Name:** ………………………………………………………………..…………………....

**Date of Birth**: …………………………………………………………………….…………………

**Parent(s) / Guardian(s):** ………………………………………………………..…………………

**Address:** …………………………………………………………………………………………….

**Phone numbers / email address:** ………………………………………………………………...

I give permission for the Psychologist to:

* Assess my child’s abilities, behaviour, and skills for learning, mental health and development. I understand that this may involve observations, interactions and interviews, and measures of cognitive, social-emotional, behavioural and academic skills.
* Use information to assist educational planning. This may involve providing verbal and written reports to schools to support curriculum adjustments, behaviour and learning plans, and educational needs.
* Seek and exchange information, including written reports if available, about my child with other professionals and agencies both within and outside the school, as follows:

Health Practitioners (e.g., Paediatrician, Psychologist, General Practitioner)

Agency and other service providers (e.g., CAMHS, Gateways Baptcare, St Giles)

Other

* Consent is given for **one year** from the date of signing, and can be extended or revoked in consultation with the School and/or Psychologist. I understand that the Psychologist file will be confidentially stored according to state and national laws.

**Signed:** ……………………………………………………………………………………………..…

**Relationship to the Student :** **……………………………………… Date: …………………….**