Adult General Information Form

Client details

Family name

Given names

Other names

Date of birth

Hospital of birth

Biological Mother's name

Ethnicity

Gender ☐ Male ☐ Female ☐ Other

ATSI details ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither

Preferred spoken language

Legal Guardian (if applicable)

Relationship to the client

Residential address

Postcode:

Postal address

Postcode:

Phone number ( )

Email

Person completing referral (if not self)

Relationship to the client

Phone number ( )

Email

Adult General Information Form

Medicare Card Number

IRN (Place on card) Expiry date

CRN

Additional details

Previous diagnoses

This referral is for:

If this referral is for Autism please fill out a Family Referral Form

☐ Forensic Psychology ☐ Intellectual Disability ☐ Autism ☐ Psychology

☐ ADHD ☐ Neuropsychology ☐ Psychiatry ☐ FASD

☐ Other:

Does the client have outstanding legal matters? ☐ Yes ☐ No

Details:

Client previously known to Child Development Services? ☐ Yes ☐ No Service:

Contact details

Email

Phone number ( )

Client known to Aboriginal Health Service? ☐ Yes ☐ No Service:

Contact details

Email

Phone number ( )

Development

Did the client have developmental assessments in the past as a child? ☐ Yes ☐ No If yes – Service(s)

Clinician details

Were there any concerns during the pregnancy with the client? ☐ Yes ☐ No

If yes, please list

Did the client's mother use alcohol or other drugs during pregnancy? ☐ Yes ☐ No

If yes, please give details

Was the client born to full term? ☐ Yes ☐ No At how many weeks' gestation were they born?

Did the client have any health concerns at birth or before their first birthday? ☐ Yes ☐ No

If yes, please give details

Were there ever concerns about the client's development as a child? ☐ Yes ☐ No

If yes, what were the concerns?

Were any health professionals seen about the client's development as a child? ☐ Yes ☐ No

If yes, please list

Are there things that the client needs help with that you would expect them to be doing themselves? ☐ Yes ☐ No

If yes, please list

What do you think the client is good at?

Medical

Does the client have any ongoing health concerns? ☐ Yes ☐ No

If yes, please list

Is the client currently taking any medication? ☐ Yes ☐ No

If yes, please give details

Has the client needed to go to hospital? ☐ Yes ☐ No

If yes, please give details including which hospital

School

At what stage of schooling did the client get to?

Please list name of schools attended and the years:

Speech Pathology

Has the client had Speech Pathology treatment or assessments in the past? ☐ Yes ☐ No

If yes, service(s)

Clinician details

Occupational Therapy

Has the client had Occupational Therapy treatment or assessments in the past? ☐ Yes ☐ No

If yes, service(s)

Clinician details

Physiotherapy

Has the client had Physiotherapy treatment or assessments in the past? ☐ Yes ☐ No

If yes, service(s)

Clinician details

Current Concerns (please list)

Psychology

Has the client had Psychological treatment or assessments in the past? ☐ Yes ☐ No

If yes, service(s)

Clinician details

Current Concerns (please list)

Other

Do you have any other concerns? ☐ Yes ☐ No

If yes, please list

What do you hope to get out of a Patches Assessment?

How did you hear about Patches?

Client/Legal Guardian consent

Your consent gives permission for you/the client to be seen by the Patches team until the client is "discharged from the service".

You may formally withdraw your consent at any time. I give my consent for Patches to:

- Undertake assessments and therapy interventions at any site, including correctional centres and clinics
- Obtain, release and exchange reports and relevant information (both written and verbally) with other agencies and individuals as required including:
    - Your/the client's nominated GP
    - Aboriginal Medical Services
    - Corrective Services/Justice
    - Any relevant Medical or other Child Development Services
    - You/the client's previous school, including School Psychologist service reports
- Make audio and/or visual recordings of you/the client for assessment, management and therapy purposes.
- I understand Patches will not administer any medication to me/the client.

Research at Patches

- As well as using the information we collect about you/the client for clinical care, we also use it for research and evaluation purposes. For example, we might use a client's data for annual reports about our service, to look at ways we can improve our service, conference presentations and/or research publications.
- Whenever we present information, we do it so that identifying information is not included
- We sometimes work with researchers from outside our clinic. The research we do is approved by a Human Research Ethics Committee and tends to look at groups of people rather than just one person (e.g. what was the average age of our clients).
- While there are no direct benefits to you/ the client from letting Patches use your/the client's information for research, this information might help us improve our understanding and treatment of various psychological and medical conditions, potentially benefiting future clients.
- It is OK if you do not want the your/the client's information used for research purposes.
- You can change your mind at any time after signing this consent form.

Confidentiality

- All medical records are stored securely. Only Patches staff members have access to these records, unless the law requires us to disclose it.
- Consistent with State Health policy and legal standard, all medical records are kept for a minimum of 7 years and then destroyed
- Your/the client's information will be used as described in this form and not otherwise disclosed (unless disclosure is required by law).

If you have any questions, we can talk to you before you sign this consent form.

- I have read and understood the information provided above. Any questions that I have asked have been answered to my satisfaction.
- I understand that if I have further questions or I wish to withdraw my consent at a later date, I may contact Patches on (08) 6280 1259.
- I give my permission for Patches to enter my/the client's information into a database with the understanding that any information used for reports, conference presentations and/or research publications will be de-identified.
- I understand that the information I provide will be kept in the strictest confidence by Patches, unless obliged to release by law.
- I understand that, if I wish, I may ask for a copy of this Information and Consent Form.

Signatures

Name of client			
Legal Guardian Name (if applicable)			
Client/Legal Guardian Signature		Date	

Send the signed and completed form to:

WA Email: diagnosis@patches.com.au
Fax: 08 6208 3202

NT Email: ntdiagnosis@patches.com.au
Fax: 08 6208 3202