Dr. Jane Lonie | Ba(Hons), MA, Phd, C.Psychol, MAPS
Clinical Neuropsychologist

Referral form

Please scan and return this form to Dr. Lonie by email.

Name of referrer: _____

Professional role: _____

Address: _____

_____

Phone: _____ Fax: _____

Email: _____

Client Details

Last Name: _____ First Name: _____

Address: _____

_____

Phone numbers (home) _____ (mobile) _____

Date of Birth: _____ Sex: ❑ *MALE* ❑ *FEMALE*

Is your client aware of this referral? ❑ *YES* ❑ *NO*

Reason for referral to Neuropsychology.

❑ Clinical / Diagnostic opinion – please give brief details below

_____

_____

_____

_____

_____

❑ **Assessment of decision-making capacity**

- ❑ Capacity to make financial decisions
- ❑ Capacity to make general lifestyle decisions
- ❑ Capacity to appoint an Enduring Power of Attorney
- ❑ Capacity to appoint a Guardian
- ❑ Testamentary capacity

❑ Other (please specify)

_____

_____

Medical history

_____

_____

Presenting Problem(s)
1.

_____

_____

2.

_____

_____

3.

_____

_____

Details of previous neuropsychological assessments

_____

_____

_____