Health
South Eastern Sydney
Local Health District

Mindgardens Functional Neurological Disorders (FND) Clinic

Referral Form

Please note - Referral to this clinic is predicated on your continued involvement in the referred patient's care

Title: (Mr / Mrs / Ms / Miss / Master / Dr / Prof / Father / Sister / Other): _____

Surname*: _____ **First Name*:** _____

Aliases: (if patient has ever been known by another name, e.g., maiden name): _____

Sex*: ☐ Male / ☐ Female / ☐ Other Which gender patient most identifies as? _____

DOB* (dd/mm/yyyy): _____ **Age:** _____

Address*: _____

Home Telephone: _____ **Mobile:** _____

Country of Birth: _____ **Preferred Language:** _____

Email*: _____ **Interpreter required*:** ☐ Yes / ☐ No

Aboriginal/Torres Strait Islander: ☐ Yes / ☐ No Health Fund Details (if applicable): _____

Medicare number: _____ Position on card: _____ Card expiry date: _____

EMERGENCY CONTACT PERSON:

Name: _____ Relationship to patient: _____

Title: (Mr / Mrs / Ms / Miss / Master / Dr / Prof / Father / Sister / Other): _____

Home Telephone: _____ Mobile: _____

Interpreter required: ☐ Yes / ☐ No

REFERRING SPECIALIST:

Name: _____

Practice Address: _____

Phone: _____ Email: _____

GENERAL PRACTITIONER (not specialist):

Name: _____

Practice Address: _____

Phone: _____ Email: _____

UNSW SYDNEY CHeBA Healthy Brains Positive Ageing mindgardens Neuroscience Network NPI Neuropsychiatric Institute

FUNCTIONAL NEUROLOGICAL DISORDER (FND) DIAGNOSIS:

Date diagnosed with FND (**month & year**): _____

Primary presenting symptoms of FND (please select from the list):

- ☐ Non epileptic seizures/ attacks
- ☐ Weakness/ paralysis
- ☐ Abnormal movement (e.g. tremor, dystonic type, myoclonus, gait disorder)
- ☐ Speech symptom (e.g. Dysphonia, slurred speech)
- ☐ Sensory disturbance (visual, olfactory, hearing)
- ☐ Cognitive disturbance causing functional impairment
- ☐ Other (please specify)

Secondary symptoms (if comorbidity) (please select from the list):

- ☐ Fatigue
- ☐ Pain syndrome – acute/ chronic
- ☐ Cognitive fog/ other cognitive issues
- ☐ Gastrointestinal symptoms
- ☐ Other (please specify) _____

Patient informed of FND diagnosis: ☐ Yes / ☐ No

Patient accepts FND diagnosis: ☐ Yes / ☐ No / ☐ Partially

FND related investigations complete: ☐ Yes / ☐ No

Are any of the below applicable currently in relation to the FND diagnosis? (please select all that apply):

- ☐ Insurance / Worker's compensation claims
- ☐ New NDIS application
- ☐ Change of circumstance to existing NDIS package
- ☐ Other legal/ medico-legal matter

Any anticipated barriers to participation (e.g.: mobility issues, sensory impairment):

_____

Any potential risk issues:

_____

Any acute mental health issues (e.g.: acute suicidality/ severe mood or other mental disorder/ active drug and alcohol issues):

_____

FND-related **hospital admissions** within last 2 years (please select one from list):

☐ 0 ☐ 1 ☐ 2 ☐ 3+

FND-related **emergency department presentations** within last 2 years (please select one from list):

☐ 0 ☐ 1 ☐ 2 ☐ 3+

FND-related **ambulance callouts** within last 2 years (please select one from list):

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4+

CURRENT HEALTHCARE PROVIDERS:

Professional	Name	Date last seen (if known)	Reason for consultation

ALCOHOL/SUBSTANCE ABUSE (Active/current):

- Alcohol abuse issue: ☐ Yes / ☐ No
- Substance abuse issue: ☐ Yes / ☐ No

PATIENT CONSENT:

Consented to referral and willing to engage in treatment: ☐ Yes / ☐ No

Consents to information being shared with care providers: ☐ Yes / ☐ No

Wishes for family involvement in assessment and treatment: ☐ Yes / ☐ No

Willing to travel for initial assessment: ☐ Yes / ☐ No

DOCUMENTS CHECK LIST:

Referral can only be considered when the following documentation has been received:

☐ A brief referral letter from you addressed to Dr Adith Mohan to accompany this form (for Medicare purposes

☐ All relevant Specialists reports

☐ Relevant investigation results

☐ Discharge summaries from previous hospital admissions (if any)

REFERRING SPECIALIST:

Our service is a tertiary, research-embedded clinical service and cannot accept referrals for ongoing care.

By signing below, you agree to remain involved in the care of this patient and to continue care at the conclusion of their engagement with our clinic.

Please also be aware that we receive a large number of referrals and therefore might have a long waitlist.

Signed: _____

Name: _____

Date: _____