Health
South Eastern Sydney
Local Health District

Mindgardens Functional Neurological Symptom 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 you have ever been known by another name, e.g., maiden name): _____

Sex*: ☐ Male / ☐ Female / ☐ Other **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)
- ☐ 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 there any ongoing medico-legal, insurance or workers compensation issues? ☐ Yes / ☐ No

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+

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

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

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

DOCUMENTS CHECK LIST:

Please send us back the following documents before the patient can be considered for inclusion in the clinic:

☐ Specialist's referral

☐ All relevant Specialists reports

☐ Relevant investigation results

☐ Discharge summaries from previous hospital admissions (if any)

REFERRING SPECIALIST:

Signed: _____

Name: _____

Date: _____