Referral & Consent to Exchange Information

Referrer:

Child/Client Name: **Date of Birth (DOB):**

Parent/Carer Name:

Contact Number: **Email:**

1. Reason for Referral: (include any current diagnoses or suspected disabilities):

2. Clinical History. Have you previously engaged with allied health or medical professionals (e.g., OT, Speech Pathology, Paediatrician)?
□ **No** □ **Yes** (Please provide details/reports if available):

3. Education. Please provide the name and contact details (phone/email) of the child's current school or preschool:

4. Funding Source (please tick and provide details):
□ **GP Referral** (Complex Neurodevelopmental Assessment) □ **Private**

□ **NDIS -** Plan Manager Name: Email:
Assessment & Billing Consent. Services are billed in accordance with the NDIS 2026–2027 pricing schedule at $252.99/hour using code 15_054_0128_1_3. By signing below, you authorise the use of the following suffixes for billing: _TH: Telehealth consultations; _NF: Clinical scoring and report writing; _CA: Cancellation fee (100% of session fee for appointments cancelled with less than two clear business days' notice).

□ I have read and agree to the billing terms and the use of the NDIS codes listed above.

Consent to Exchange Information

I, _____ (parent/carer), give permission for Lisa Butcher (Patronus Psychology) to exchange information relevant to the assessment and care of my child with their school, health professionals, and other involved parties as needed.

I understand this information will only be shared to support my child's assessment and wellbeing, and that I may withdraw this consent at any time.

Signature of Parent/Carer/Legal Guardian: _____
Date: ____ / ____ / ____

Please email the completed form to lisa@patronuspsychology.com.au

Patronus Psychology lisa@patronuspsychology.com.au
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