VRAELYS/QUESTIONNAIRE

Streng Vertroulik/Strictly Confidential

Voltooi asseblief so volledig moontlik Please fill out the questionnaire

Evaluasie Datum…… Date of Assessment…….....

1. PERSOON VERANTWOORDELIK VIR REKENING / PERSON RESPONSIBLE FOR ACCOUNT

Van Dr Mnr Mev Mej
Surname …… Dr Mr Mrs Miss
Voorname
First Names ……
I D Nommer
I D Number……..
Woonadres
Home Address……Kode/Code……
Werkgewer
Employer……
Werksadres Kode
Work Address……Code……..
Tel. (H)……Tel (B)……Sel/Cell……
E-pos/E-mail……..

2. MEDIESE FONDS/MEDICAL AID

Naam Nommer
Name…… Number
……..
Hooflid se Naam I D Nr.
Name of Main Member……. I D No……
Tel. (H)……Tel. (B)…… Sel/Cell……

3. OUERS: AGTERGRONDGESKIEDENIS / PARENTS: BACKGROUND HISTORY

VADER / FATHER

- Naam/Name……
- Hoërskool / High School ……Jaar /Year……
- Hoogstegraad geslaag / Highest grade passed ……Jaar/Year……
- Naskoolse Opleiding/TertiaryTraining ……Jaar/Year……
  (Instansie/Institution) ……
- Beroep / Occupation……Werkgewer / Employer……

Mediese geskiedenis / Medical History

- Allergieë / Allergies……
- Skolastiese Probleme / Learning Disabilities……

Dr Elizabeth Hefer, Educational Psychologist, 326 Wynandskraal Street, Erasmusrand,
Pretoria. Website: elizabethhefer.co.za, E-mail elizeh@internext.co.za
GPS Co-ordinates: -25,807344 28,283430

MOEDER / MOTHER
Naam/Name ……
Hoërskool / High School…….. Jaar/Year…….
Hoogste Graad geslaag/Highest grade passed……..Jaar/Year……..

- Naskoolse opleiding/Tertiary training……Jaar/Year…….
  Instansie/Institution
- Beroep/Occupatioin……
- Werkgewer/Employer……

Mediese Geskiedenis/Medical History

- Allergieë/Allergies……
- Skolastiese probleme/Learning disabilities…….

GESINSAMESTELLING/SIBLINGS
Naam en ouderdom: ……..
……

4. KLIËNT/ CLIENT

Van /
Surname……..
Naam / Name……
Geboortedatum/Date of birth……..
Geslag/Sex……..
Ouderdom/Age……
Skool/School…….
Graad/Grade……
Graad herhaal / Grade failed……
Klasonderwyser en tel nr……
Class teacher and tel no……
Prinsipaal / Principal……
Verwys deur/
Referred by……
Hoofklagte/
Main complaint……

5. AGTERGRONDGESKIEDENIS VAN KLIËNT/BACKGROUND HISTORY OF CLIENT

Gesondheid met swangerskap/Health during pregnancy

Swangerskapsduur/Duration of pregnancy……
Geboorte prosedure: Normaal……Tyd in kraam (ure).....Keisersnee.....
Birth procedure: Normal……..Duration of labour……..Caeserian Section……
Naelstring om nek/Umbilical cord around neck……Refluks/Reflux……Koliek/Colic……
Borsvoeding/Breastfed……Bottel/Bottle……..
Geboorte gewig/Birth weight……
Allergieë/Allergies……..

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Ontwikkelingsmylpale (ouderdom in maande)
Developmental Milestones (age in months

- Sit……
- Kruip/Crawl……
- Loop/Walk……
- Woorde/Words……..
- Sinne/Sentences……
- Toilet gebruik op/Potty trained at……
- Van doeke af/Off diapers……..

Siektegeskiedenis/Childhood Diseases/Sickness

- Koorsstuipe/Fever fits……
- Kindersiektes/Child diseases (ouderdom/age)……..
- Ander siektes/Other diseases (ouderdom/age)……
- Hoofbeserings/Head injuries (ouderdom/age)……
- EEG Y/N Date
- MRI Y/N Date
- Mediese verslae/Medical reports……
- Hospitalisasie Ja/Nee …….. Datum…….. Rede……
- Hospitalization Yes/No …….. Date…….. Reason
- Operasies Ja/Nee …… Datum…… Rede……
- Operations Yes/No …… Date…….. Reason……
- Oorinfeksies Ja/Nee …… Datum…….. Grommets……..
- Ear infections Yes/No …… Date……..Grommets……
- Visie: Oogtoets Ja/Nee …… Ouderdom…… Disfunksie……..
- Vision: Eye test Yes/No…… Age……. Dysfunction……

Eetgewoontes/Eating habits

Eetlus/Appetite……..
Slaappatroon/Sleeping pattern ……
Gewoontes/Habits

- Duimsuig/Thumb sucking (ouderdom/age)……
- Naelbyt/Nailbiting (ouderdom/age)……
- Kopstamp/Head banging (ouderdom/age)……
- Trekkings, Obsessies/Tics, Obsessions (age/ouderdom)

Gedrag Huis…….. Skool……..
Behaviour Home……..
School……

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6. SKOLASTIESE AGTERGROND/SCHOLASTIC BACKGROUND

Speelgroep/Dagmoeder Playgroup/Day care: Name……Age……
Skooltaal/School Lanaguage:
……
Kleuterskool/Nursery School: Name……Age……

Skooltaal/School Language……

Pre-Primêre Skool/Pre-Primary School Name……Age……..
Skooltaal/School Language……

Primêre Skool/Primary School Name……..Grade……
Skooltaal/School Language……

Hoërskool/High School Name……Grade……
Skooltaal/School Language……

Tersiêre Opleiding: Naam……Kursus……..Jaar……
Tertiary Training: Name……Course……..Year……

Skool Weiering/Fobia School Refusal/Phobia ……
……
……

Sport: Soort/Type……Ouderdom/Age……
…… ……
…… ……
……
…….

7. VORIGE EVALUASIES/PREVIOUS ASSESSMENTS

Fisioterapie/Physiotherapy:
Terapeut/Therapist……Ouderdom/Age…….

Arbeidsterapie/Occupational Therapy:
Terapeut/Therapist……Ouderdom/Age…….

Spraakterapie/Speech therapy:
Terapeut/Therapist…… Ouderdom/Age……..

Neuro-ontwikkelingspediater/Neuro-developmental Paediatrician

Dr……..Ouderdom van kind/Child's age
Ander/Others: Name……Ouderdom van kind/Child's age

8. VORIGE TERAPIE/PREVIOUS THERAPY

Fisioterapie/Physiotherapy Ja/Nee Tydsduur……
Yes/No Duration……

Arbeidsterapie/Occupational therapy Ja/NeeTydsduur……
Yes/No Duration……

Spraak/taalterapie/ Speech/language therapy Ja/Nee Yes/No Tydsduur…… Duration……

Remediërende Klasse/Remedial Education Ja/Nee Tydsduur/Duration……

Ekstra klasse/Extra classes: Vakke/Subjects…… Grade……..
…… Grade……..
…… Grade……..
Ander terapie/Other type of therapy: …… Tydsduur/Duration……

Medikasie/Medication: Dr…….. Grade……..

9. VERSLAE/REPORTS

Spraak/taalterapie/ Speech/language therapy	Ja/Nee Yes/No
Arbeidsterapie/Occupational therapy	Ja/Nee Yes/No
Neuroloog/Neurologist	Ja/Nee Yes/No
Pediater/Paediatrician	Ja/Nee Yes/No

Bring verslae asseblief saam met eerste konsultasie.
Please bring reports with the first consultation

10. TRAUMATIESE GEBEURE/TRAUMATIC EXPERIENCES

Voorval/Incident…….. Ouderdom/Age……..
…….. ……..
…….. ……..
…….. ……..

Toestemming vir Sielkundige Evaluasie

Hiermee verleen ek----------, vader/moeder van

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toestemming dat my kind na dr. Elizabeth Hefer, Opvoedkundige Sielkundige, vir 'n sielkundige evaluasie en terapie mag gaan. Die evaluasie sluit in (merk van toepassing):

☐ Ouerbegeleiding

☐ Ontwikkelingsevaluasie

☐ Skoolgereedheidsevaluasie

☐ Skolastiese en Intellektuele Evaluasie
(Skolastiese probleme)

☐ Evaluasie: ☐ Gedragsprobleme
☐ Emosionele Probleme
☐ Sosialiseringsprobleme
☐ Vakkeuses
☐ Skoolplasing
☐ Aansoek vir Spesiale Konsessies
☐ Neurofeedback

☐ Beroepsleiding

☐ Verslag – Kliënt self vir betaling van verslag verantwoordelik

Adres: ……..

Tel nr: ……

Selnr:
……

ID nr: ……

Epos adres: ……..

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-
Handtekening van vader **Datum**

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Handtekening van moeder **Datum**

Pretoria. Website: elizabethhefer.co.za, E-mail elizeh@internext.co.za
GPS Co-ordinates: -25,807344 28,283430

Consent of Permission for a Psychological Assessment

I, ……, father and mother, hereby give permission for (child's name)…….. to see Dr Elizabeth Hefer, Educational Psychologist, for a psychological assessment and therapy, which include the following (check all that apply):

☐ Developmental Assessment

☐ Parental Guidance

☐ School Readiness Assessment

☐ Scholastic and Intellectual Assessment (scholastic difficulties)

☐ Assessments :
- ☐ Behavioural Difficulties
- ☐ Emotional Difficulties
- ☐ Social Difficulties
- ☐ Choice of school subjects
- ☐ School placement
- ☐ Application for Special Concessions
- ☐ Neurofeedback

☐ Career Guidance

☐ Written Report – client is responsible for the payment

Address: ……

Tel no: ……

Cellphoneno: ……

ID no: ……

Email Address: ……

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Signature of father **Date**

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Signature of mother **Date**

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Dr Elizabeth Hefer – Psychology Practice
PRACTICE INFORMATION

Procedure for Appointments

* Appointments will be scheduled at a time mutually acceptable to both the patient and the psychologist. We require 24 hour advance notice of cancellations except in an extreme emergency. Appointments missed or cancelled in less than 24 hours will be charged at the usual rate.

*According to the lawboth parents are required to sign the consent of permission for a psychological assessment.

***Please note that the first consultation/evaluation must be paid in full by the patient. The amount may be claimed back from the medical aid.**

COPY OF CONTRACT

- I, the undersigned, undertake to give 24 hour advance notice of the cancellation of appointments. Appointments missed or cancelled in less that 24-hour notice, will be charged at the normall rate.
- I, the undersigned, am responsible for payment of the full amount on my account if my medical aid does not settle within **30 days**.
- I, the undersigned, undertake to pay collecting charges for unpaid fees when my account is not paid in full within 30 days. Interest at a rate of 2.2% per month will be charged on unpaid fees older than **30 days**.
- I, the undersigned, declare that my address as given in this file is "domicilium citandi et executandi" for receiving documents or and letters of execution.
- I, the undersigned will notify the practice in writing of any changes to my physical address, postal address and or contact details;
- The practice is entered and visited at own risk. The practice is not liable for any accidents and/or injuries sustained by the client or will not be held responsible for any emotional and physical problems that may be activated by sound and light technology and hypnoses at the practice.
- I, the undersigned, declare that I will not use reports or any information received from the practice for any action at law, without the knowledge and permission of dr Elizabeth Hefer.
- The practice charges according to the national reference price list for psychologists which will adjust annually. (Please take note of your medical aid's price list).
- **Written reports are not covered by medical aid. Only on receipt offull pament,will the report be formulated and completed.**
- I, the undersigned, understand that all claims tendered to a medical aid require an ICD 10 (diagnoses code). I hereby give permission to disclose an ICD10 diagnosis code on my account.
- I, the undersigned, understand that my case might be confidentially discussed with a registered senior psychologist for supervision purposes. Confidentiality regarding my name or identity will be upheld. In the case of my child/children, the case may be confidentially discussed with a registered psychologist, speech therapist, occupational therapist, neurologist, paediatrician or general practitioner for referral purposes (attached, Authorization to Release Information).
- I, the undersigned, understand that my child's case may be confidentially discussed with the class teacher or principal at school to support my child effectively (attached, Authorization to Release Information).

PROCEDURES TO ENSURE PROMPT PAYMENT OF ACCOUNTS

Following the given procedure will enable both parties to ensure that accounts are settled promptly.

Payments can be settled by:

- Cash payments 24 hours before assessment
- Internet payments at the practice.

Tel: 0836282616 en083 492 3763 (office number)
Fax: 086 560 0756
e-mail: elizeh@internext.co.za
Office Hours: 8h45-17h00 (Monday-Thursday)
8h00 - 13h00 (Friday)
Account Enquiries: 9h00-12h00 (Monday-Friday)

It remains the patient's responsibility to ensure prompt payment of accounts. An account will be sent to the patient as well as the medical aid. Amounts not paid by the medical aid must promptly be settled by the patient to avoid collection costs.

IMPORTANT INFORMATION TO QUOTE WHEN PAYING ACCOUNTS

	Account Holder:	**Dr Elizabeth Hefer**
	Bank:	**ABSA**
	Account no:	**1340162109**
Branch name:	**Veale Street Brooklyn**	
	Branch Code:	**335 345**

Quote **your name** and **account number** reflected on your statement at all times when paying or corresponding. Fax copy of deposit slip to 0865600756 and ensure legibility and receipt thereof.

Signature…… Date: …….....