The Storrie-Velikonja Need for Psychological/Neuropsychological Assessment Screening Questionnaire (SVSQ)

The SVSQ is a screening questionnaire designed to help non-Psychologists determine whether it is appropriate to refer patients or clients showing psychoemotional or neurocognitive signs for Psychological or Neuropsychological Assessment.

The SVSQ is designed to be administered by you, and should not be given to the patient/client for self-administration. It is not intended to be diagnostic or exhaustive, but to provide information relevant to help you determine whether Psychological or Neuropsychological Assessment is indicated.

Administering the SVSQ does not require specific education or training.

Mood

- ❑ Do you feel sad, unhappy and discouraged most of the time?
- ❑ Do activities that used to interest you no longer bring you pleasure or enjoyment?
- ❑ Do you have difficulty concentrating and making decisions most of the time?
- ❑ Do you feel agitated, and unable to sit or stand still?
- ❑ Do you feel worthless?
- ❑ Do you feel alone or isolated?
- ❑ Have there been changes in your appetite, energy level, sleeping pattern or sexual interest?
- ❑ Have you been told that there have been changes in your personality and/or behaviour?
- ❑ Do you have recurrent thoughts of death, dying, and/or suicide?

Anxiety

- ❑ Do you feel uneasy and apprehensive most of the time?
- ❑ Do you feel unusually restless, irritable, tense or distractible?
- ❑ Do you avoid leaving the house or going to places where there is a crowd?
- ❑ Have you experienced sudden episodes of extreme panic (which can include chest pain, trembling, sweating, heart palpitations and shortness of breath) and felt like you were going to lose control, pass out, or die?
- ❑ Have you changed your behaviour or avoided certain places and/or activities so you will not have another attack?

Fear

- ❑ Do you have an extreme fear of an object or situation, but recognize your fear is excessive or unreasonable?
- ❑ Does fear interfere with your ability to function normally at work or home?
- ❑ Are you fearful of acting inappropriately or being obviously anxious in social situations?
- ❑ Are you nervous when travelling in a motor vehicle?
- ❑ Are you afraid that you will be in another accident?
- ❑ As a passenger, do you press an imaginary brake or tell the driver what to do?
- ❑ Do you avoid driving whenever possible?
- ❑ Do you avoid travelling by car unless you are the driver?

Traumatic Experiences

- ❑ Do you have disturbing recollections about a traumatic event you've experienced?
- ❑ Do you have disturbing dreams about a traumatic event you've experienced?
- ❑ Do you relive a traumatic event you've experienced?
- ❑ If you are exposed to something that reminds you of the traumatic event, or if you think about the event, do you feel distress and/or experience physical symptoms such as heart palpitations or dizziness?
- ❑ Do you have difficulty relaxing, sleeping, and/or concentrating, or are more easily startled as a result of your traumatic experience?

Pain

- ❑ Are you having difficulty coping with your pain?
- ❑ Does your pain significantly interfere with your activities?
- ❑ Are your thoughts are constantly consumed with your pain, or how you might relieve your pain?

Cognitive Changes

- ❑ Are you more forgetful than is usual for you?
- ❑ Do you lose track of conversations, or your train of thought?
- ❑ Is the word you want to use on the tip of your tongue?
- ❑ Is it difficult to remember the names of people you know?
- ❑ Do you now prefer to leave decision-making to others?
- ❑ Do you find it very difficult to focus?

Head Trauma

- ❑ Did you hit your head or lose consciousness/awareness in the accident?
- ❑ Are there gaps in your memory for the circumstances surrounding the accident?
- ❑ Do you have frequent headaches?
- ❑ Have you been told that you suffered a concussion in the accident?
- ❑ Do you sometimes say things you shouldn't?

If your patient/client reports experiencing any of the above, he or she may require a Psychological or Neuropsychological Assessment to determine the nature and extent of psychoemotional or neurocognitive impairment.

STORRIE, VELIKONJA AND ASSOCIATES
REFERRAL FORM

Date of Referral: _____

Name of Patient: _____

Patient's Telephone Number: _____

Reason for Referral:

❑ **Psychological Assessment** ❑ **Neuropsychological Assessment** ❑ **Psychological Counselling**

Brief Description of Presenting Complaints: _____

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_____

Referred By: _____

Your Telephone Number: _____

PLEASE FAX COMPLETED REFERRAL FORM TO (905) 333-0082