# New Referral Form

Please select:

☐ Occupational Therapy Referral ☐ Speech Pathology Referral

| | | | |
|---|---|---|---|
| Child's Name | | | |
| Carer/s Name/s | | | |
| DOB | | Age | |
| Gender/ Preferred Pronouns | | | |
| Diagnoses (if any) | | | |
| Phone | | | |
| Address | | | |
| Email Address | | | |
| Referred by | | | |
| School/Day Care | | | |
| Days/Hours Attendance | | | |
| School/Day Care Contact (name & email) | | | |

Funding Information – please select:

| | | |
|---|---|---|
| ☐ | Private paying | |
| ☐ | Medicare Enhanced Primary Care Plan (EPC) | |
| ☐ | Medicare Mental Health Care Plan (MHCP) | |
| ☐ | NDIS Early Years | |
| ☐ | NDIS | |
| If NDIS, how are your funds managed? | ☐ | Self Managed |
| | ☐ | Provider/Agency Managed |
| | ☐ | Plan Managed |
| | ☐ | Name of Plan Manager: |
| If NDIS, please complete: | NDIS Number: | |
| | Start Date of Plan: | |
| | End Date of Plan: | |

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Email: admin@occtherapy.com.au

# Communication & Consent Form

Please include names & contact details of other professionals that you give permission for us to communicate with regarding your child.

| | |
|---|---|
| Paediatrician | |
| Psychologist | |
| Physiotherapist | |
| Occupational Therapist | |
| Speech Pathologist | |
| GP | |
| School Contact/s (teacher, learning support, guidance officer) | |
| NDIS Support Coordinator (if applicable) | |
| NDIS Local Area Coordinator (if applicable) | |
| Other | |

*If you've indicated any professionals above, please provide us with any reports that are available.*

**Please read and complete below to give consent for OCC Therapy to provide services for your child.**

As the parent or guardian of _____, I give permission for my child to receive services from OCC Therapy, and in doing so consent to and understand the following:

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| ☐ | That Occupational Therapy/ Speech Pathology services will be provided by qualified and registered therapists. |
| ☐ | That strict confidentiality and respect for my privacy is maintained at all times by any staff member/s that are involved in direct or indirect service provision to my child, in accordance with professional practice standards and the Australian National Privacy Principles. |
| ☐ | That appropriate records and documentation regarding services provided to my child will be recorded and filed securely. |
| ☐ | That I may terminate sessions, request a review or request a different therapist at any time and that I may provide feedback or express concerns at any time and expect action to be taken. |
| ☐ | That I have the right to expect appropriate and quality services. |
| ☐ | That therapy may be terminated if payment is not received within one month of service. |
| ☐ | That information will only be sought or disseminated to those listed in the above table. |

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: _____

# Initial Questionnaire

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| **Reason for Referral – What are your main concerns and priorities?** | |
| | |
| **What are your child's interests and strengths?** | |
| | |
| **Family Background** | |
| Who lives with your child – carers, siblings? | |
| Family circumstances/care arrangements that we need to be aware of? | |
| **Medical History** | |
| Mother's general health during pregnancy (illness, etc.) | |
| **Was your child born at term?**<br><br>**Were there any complications?** | |
| Has your child had any major illnesses or surgical procedures? If yes, please describe, e.g.,<br>• Recurrent colds or ear infections<br>• Tonsils removed<br>• Adenoids | |
| Has hearing and vision been assessed? If so, when? | |
| Does your child take medications? If so, what are they? | |
| **Developmental History** | |
| **Did your child reach their developmental milestones with the typical range?**<br><br>If not, when did they reach their milestones? | First Word _____<br>Combining two words (more drink) _____<br>Sit _____ Crawl _____<br>Walk _____ |
| Does/did your child have difficulty with feeding (sucking, chewing, etc.)? | |

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| **Is your child diagnosed with a developmental condition or disability?** Please provide details<br><br>Is your child aware of their diagnosis? | |
| **Communication Skills** | |
| Is your child exposed to a language other than English? | If yes, what language? _____<br>☐ Your child speaks this language<br>☐ You child understands this language<br>☐ English was your child's first language |
| How does your child usually communicate (gestures, single words, sentences)? | |
| **Does your child have difficulty with any of the following?** | ☐ Unclear speech sound production<br>☐ Using spoken language (vocabulary, using grammar, formulating sentences)<br>☐ Understanding spoken language (concepts)<br>☐ Following directions<br>☐ Reading and Spelling<br>☐ Reading comprehension<br>☐ Social Communication<br>☐ Stuttering |
| Please provide details: | |
| When was the difficulty first noticed? Who by? | |
| Is the child aware of the difficulty? How do they feel about it? | |
| Does anyone else in the child's family have a disability or current or previous speech or language problem? | |
| **Learning and Education** | |
| **Does your child have difficulty with any of the following?** | ☐ Fine motor skills<br>☐ Handwriting and drawing<br>☐ Attention<br>☐ Memory<br>☐ Planning and organizing<br>☐ Copying from the board |

| | |
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| Please provide details: | |
| Does your child receive any extra help at school/day care?<br>Please describe: | |
| **Self Care Skills** | |
| **Does your child have difficulty with any of the following?** | ☐ Sleep (eg difficulty going to sleep, night waking)<br>☐ Toileting (eg delays, constipation, bed wetting)<br>☐ Dressing<br>☐ Eating and using utensils<br>☐ Food allergies/intolerances, reflux/vomiting<br>☐ Food preparation/domestic skills |
| Please provide details: | |
| **Social and Play Skills** | |
| **Does your child have difficulty with any of the following?** | ☐ Playing with other children<br>☐ Repetitive play or particular play or sensory preferences<br>☐ Playing at home<br>☐ Participating in social activities (home or community?)<br>☐ Gross motor skills (playground or sport participation) |
| Please provide details: | |
| **Emotional Regulation** | |
| **Does your child have difficulty with any of the following?** | ☐ Emotional regulation<br>☐ Mental health concerns<br>☐ Sensory processing (eg. sensitivities or sensory triggers?)<br>☐ Disruptive or impulsive behaviour |
| Please provide details: | |
| **Further Information** | |
| Any more information you would like to share? | |