

Office Use Only

- Referral Received: ___/___/___
- Previous Client
- Prev. Discharge Date ___/___/___
- Discharge Reason
- Standard Process
- Fastracked

Children and Youth Services Referral Form



Children who meet the eligibility criteria for services will be accepted for the therapy service program funded by Disability Services Commission



Personal Details

Child's First Name(s):			
Child's Family Name:			
Date of Birth:		Child's Sex: <i>(please circle)</i>	<input type="checkbox"/> (F) <input type="checkbox"/> (M)
Home Address:			
			Postcode:
Country of Birth:			
Australian Residency Status:	<input type="checkbox"/> Permanent	<input type="checkbox"/> Temporary	<input type="checkbox"/> Other
<i>If you have ticked Other please give details:</i>			

What is the main language spoken in the child's home?	
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Does the child require interpreter services?		
<input type="checkbox"/> No	<input type="checkbox"/> Yes (for spoken language other than English)	<input type="checkbox"/> Yes (for non-spoken communication, Makaton etc)

What is the child's <i>most</i> effective method of communication?	✓ Tick
Uses speech to say what they want	<input type="checkbox"/>
Uses sign language to say what they want	<input type="checkbox"/>
Uses a communication device to say what they want (e.g. Canon Communicator, Compic)	<input type="checkbox"/>
Little or no effective communication	<input type="checkbox"/>
Child under 5 years old	<input type="checkbox"/>

Is the child of:	✓ Tick ONE only
Aboriginal but not Torres Strait Islander origin	<input type="checkbox"/>
Torres Strait Islander but not Aboriginal origin	<input type="checkbox"/>
Both Aboriginal and Torres Strait Islander origin	<input type="checkbox"/>
Neither Aboriginal nor Torres Strait Islander origin	<input type="checkbox"/>

Does the child:	✓ Tick ONE only
Live alone	<input type="checkbox"/>
Live with Family	<input type="checkbox"/>
Live with others <i>If Yes, please give us details of who the child lives with:</i>	<input type="checkbox"/>

Residential setting: Please tick one (1) only which best describes the child's living arrangements for 4 or more days per week:	
Private residence	<input type="checkbox"/>
Residence within an Aboriginal/Torres Strait Islander community	<input type="checkbox"/>
Supported accommodation facility domestic scale – <i>group homes (i.e., 24-hour supervision/care and less than 7 people)</i>	<input type="checkbox"/>
Supported accommodation facility – <i>hostels (i.e., 7 or more people and 24-hour supervision/care)</i>	<input type="checkbox"/>
Short term crisis accommodation or transitional accommodation	<input type="checkbox"/>
Other: <i>Please give details of other accommodation arrangements</i>	<input type="checkbox"/>

 Compensation: – if applicable	✓ Tick
Are you applying for compensation for the child?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you currently receiving compensation on behalf of the child?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes to either of the above, please provide the Solicitor's name, address and contact details:	

**ONLY ANSWER THE FOLLOWING QUESTION IF THE CHILD IS
15 YEARS OF AGE OR OLDER.**

Is the child:			
<input type="checkbox"/> Employed	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Not looking for work	<input type="checkbox"/> Still at school

**ONLY ANSWER THE FOLLOWING QUESTION IF THE CHILD IS
16 YEARS OF AGE OR OLDER.**

What is the child's main source of income?	
Disability Support Pension <i>(If ticked please provide the child's Centrelink No) _____</i>	<input type="checkbox"/>
Other pension or benefit <i>(not superannuation)</i>	<input type="checkbox"/>
Receiving compensation <i>(If ticked fill in Compensation Section on page 2)</i>	<input type="checkbox"/>
Other <i>(superannuation, investments, etc)</i>	<input type="checkbox"/>
Paid employment	<input type="checkbox"/>
Nil income from any source	<input type="checkbox"/>



Disability

- Please show the child's main disability by ticking one (1) box only against Primary Disability.
- Tick all other significant disabilities in the column headed Other Significant.

TYPE OF DISABILITY	Primary Disability ✓ Tick one (1) box only	Other Significant ✓ Tick as many as apply
1. Cognitive or Learning Disability		
Acquired brain injury ¹	<input type="checkbox"/>	<input type="checkbox"/>
Specific learning (<i>other than Intellectual</i>) ²	<input type="checkbox"/>	<input type="checkbox"/>
Attention Deficit Disorder ^{2,1}	<input type="checkbox"/>	<input type="checkbox"/>
2. Intellectual Disability		
Developmental delay (<i>applies to 0-5 year olds only</i>) ⁴	<input type="checkbox"/>	<input type="checkbox"/>
Intellectual Disability (<i>including Down Syndrome</i>) ⁵	<input type="checkbox"/>	<input type="checkbox"/>
3. Autism Spectrum Disorder		
Asperger's Syndrome ³	<input type="checkbox"/>	<input type="checkbox"/>
Autism ³	<input type="checkbox"/>	<input type="checkbox"/>
PDD ³	<input type="checkbox"/>	<input type="checkbox"/>
4. Neurological Disability		
Multiple Sclerosis ⁶	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy ⁷	<input type="checkbox"/>	<input type="checkbox"/>
OTHER Neurological ⁷ (please specify): _____	<input type="checkbox"/>	<input type="checkbox"/>
5. Physical Disability		
Cerebral Palsy ⁸	<input type="checkbox"/>	<input type="checkbox"/>
Motor Neurone Disease ⁹	<input type="checkbox"/>	<input type="checkbox"/>
Muscular Dystrophy ¹⁰	<input type="checkbox"/>	<input type="checkbox"/>
Para/Quadri/Tetra Hemiplegia ¹¹	<input type="checkbox"/>	<input type="checkbox"/>
Spina Bifida ¹²	<input type="checkbox"/>	<input type="checkbox"/>
OTHER Physical ¹³ (please specify): _____	<input type="checkbox"/>	<input type="checkbox"/>
6. Sensory Disability		
Deafblind (<i>dual sensory</i>) ¹⁵	<input type="checkbox"/>	<input type="checkbox"/>
Blind/Vision (<i>sensory</i>) ¹⁶	<input type="checkbox"/>	<input type="checkbox"/>
Deaf/Hearing (<i>sensory</i>) ¹⁷	<input type="checkbox"/>	<input type="checkbox"/>
Non Verbal/Speech Impairment ¹⁸	<input type="checkbox"/>	<input type="checkbox"/>
7. Psychiatric ¹⁴ (please specify): _____	<input type="checkbox"/>	<input type="checkbox"/>
8. Other Disability ¹⁹ (please specify): _____	<input type="checkbox"/>	<input type="checkbox"/>



Care and Support Needs

ANSWER THE FOLLOWING QUESTIONS FOR CHILDREN OF ALL AGES

	Has the child had, or going to have, surgery or specialist medical intervention? <i>(If Yes please give details)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Does the child need special straps for the bus or car? <i>(If Yes please give details)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Does the child need equipment or aid for mobility, communication, and/or self care? <i>(If Yes please give details)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Does the child often cough, choke or gag during mealtimes? <i>(If Yes please give details)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have any other concerns about your child's health? <i>(If Yes please give details)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No

Tick one (1) box in each area that best describes the child's need for help or supervision.

- eg if your child always needs help with dressing, but is able to perform effectively in other areas of self care, you would select "Always needs help or supervision", which is the highest level of need for that area.

	Always needs help or supervision	Sometimes needs help or supervision	Does not need help <u>but uses</u> aids or equipment	Does not need help and <u>does not use</u> aids or equipment
Self Care: <ul style="list-style-type: none"> • Washing • Dressing • Eating • Toileting 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mobility: <ul style="list-style-type: none"> • Moving around at home and/or away from home. Includes: <ul style="list-style-type: none"> - Walking - Getting in/out of bed or a chair - Using public transport 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communication: <ul style="list-style-type: none"> • Making themselves understood • Understanding others 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interpersonal Relationships: <ul style="list-style-type: none"> • Can make and keep friends • Behaves in acceptable ways • Copes with feelings 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**ONLY ANSWER THE FOLLOWING QUESTION IF THE CHILD WILL BE
5 YEARS OF AGE OR OLDER BEFORE JULY 1ST.**

	Always needs help or supervision	Sometimes needs help or supervision	Does not need help <u>but uses</u> aids or equipment	Does not need help and <u>does not use</u> aids or equipment
Learning: <ul style="list-style-type: none"> • Understanding new ideas • Remembering • Problem solving • Making decisions • Paying attention • Doing single or multiple tasks • Carrying out daily routines 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Education: <ul style="list-style-type: none"> • Tasks required at school 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Community Participation: <ul style="list-style-type: none"> • Recreation and leisure • Handling money • Shopping 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>


**ONLY ANSWER THE FOLLOWING QUESTION IF THE CHILD WILL BE
15 YEARS OF AGE OR OLDER BEFORE JULY 1ST.**

	Always needs help or supervision	Sometimes needs help or supervision	Does not need help <u>but uses</u> aids or equipment	Does not need help and <u>does not use</u> aids or equipment
Domestic Life <ul style="list-style-type: none"> • Making meals • Cleaning • Cooking • Shopping 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work skills <ul style="list-style-type: none"> • Work experience • Part time work • Voluntary work experience • School based work skills training programs 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Community Participation

What is the child's usual day activity? (you may tick more than one box):		
<input type="checkbox"/> No formal day activity	<input type="checkbox"/> Day Care	<input type="checkbox"/> Child Care
<input type="checkbox"/> Kindergarten	<input type="checkbox"/> Pre-school	<input type="checkbox"/> Home School
<input type="checkbox"/> Education Support Centre	<input type="checkbox"/> Education Support School	<input type="checkbox"/> School

School Information	
Name of School/Centre(s):	
Address:	
Suburb:	Postcode:
Telephone Number:	
 Teacher's Name:	
Current School Year:	
Is the child changing schools/child care in the next 12 months:	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes , do you know what date:	
Name of School/Centre(s) your child will attend:	

Services and Agencies Previously and Currently Involved in Care of the Child	
Princess Margaret Hospital:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other Hospital <i>(please specify):</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child Development Centre <i>(please specify):</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please describe Therapy/services received:	
Are you currently receiving services from any other service provider? <i>(e.g. Autism Association, The Centre for Cerebral Palsy, Disability Services Commission etc)</i>	<input type="checkbox"/> Yes <i>(please give details)</i> <input type="checkbox"/> No
Are you currently waitlisted with any other service providers? <i>(e.g. Autism Association, The Centre for Cerebral Palsy, Disability Services Commission etc)</i>	<input type="checkbox"/> Yes <i>(please give details)</i> <input type="checkbox"/> No
Other Agencies currently involved in providing services to your child <i>(e.g. Local Area Coordinator, Autism Association, Resource Unit for Children with Special Needs, Department for Community Development, etc):</i>	<input type="checkbox"/> Yes <i>(please give details)</i> <input type="checkbox"/> No
Family Doctor/GP:	Name: Location:
Specialist Doctor:	Name: Location:
Specialist Doctor:	Name: Location:



Parent/Carer/Guardian Information

A carer is someone who provides a significant amount of care to the child, generally for a period of 6 months or longer. Care can be provided formally or informally.

A formal carer is a paid or unpaid person arranged to provide care by a service provider. Usually a formal carer is unrelated to the child.

An informal carer includes a mother, father, a host family, foster family, friends and other family members who may receive a pension or benefit for their caring role.

Primary Carer (tick ONE only): <input type="checkbox"/> Informal (<i>Please complete Page 10</i>) <input type="checkbox"/> Formal			
First Name:			
Family Name:			
Address (if different from child):			
Suburb:		Postcode:	
Home Phone:		Work Phone:	
Mobile:		Email:	
Main Language spoken at home:		Interpreter Required?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Secondary Carer (tick ONE only): <input type="checkbox"/> Informal <input type="checkbox"/> Formal			
First Name:			
Family Name:			
Address (if different from child):			
Suburb:		Postcode:	
Home Phone:		Work Phone:	
Mobile:		Email:	
Main Language spoken at home:		Interpreter Required?	<input type="checkbox"/> Yes <input type="checkbox"/> No

You may add other carers involved with the child on a separate sheet of paper

IF THE CHILD DOES NOT HAVE AN INFORMAL CARER SKIP THE REST OF THIS PAGE			
What is the relationship of the primary INFORMAL carer to this child?			
<input type="checkbox"/> Mother	<input type="checkbox"/> Other female relative	<input type="checkbox"/> Female friend/neighbour	
<input type="checkbox"/> Father	<input type="checkbox"/> Other male relative	<input type="checkbox"/> Male friend/neighbour	
Does the main carer live in the same household as the child?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If the child is under 16, does the carer receive Carer's Allowance from Centrelink for the child:		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If YES please provide the child's Centrelink Number:			
What age group does the Main Carer fit into?			
<input type="checkbox"/> 15-24 years	<input type="checkbox"/> 25-44 years	<input type="checkbox"/> 45-64 years	<input type="checkbox"/> 65 years and over
Does the carer assist the child in the area(s) of self-care, mobility or communication?		<input type="checkbox"/> Yes <input type="checkbox"/> No	



Parent/Guardian Consent

Child's Name: _____
(First Name) (Family Name)

Parent/Guardian Name(s): _____
(First Name) (Family Name)

I / We give Therapy Focus consent to access reports and information regarding the child so Therapy Focus can assess if he/she is eligible to receive services.

These may include:

- Psychological Reports
- Medical Reports
- Therapy Reports
- Educational Reports
- Other Reports

I / We give consent for Therapy Focus to work with the child and for:	
• My/our child to sometimes receive services from a student working under a Therapy Focus staff member	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Therapy Focus to share information about the child with:	
- School authority	<input type="checkbox"/> Yes <input type="checkbox"/> No
- Medical or Therapy personnel	<input type="checkbox"/> Yes <input type="checkbox"/> No
- Other (please specify)	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Therapy Focus to photograph or video the therapy session/s provided to the child for use in therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No

I/We understand this consent will stay in place while the child is receiving services from Therapy Focus. I/we agree to advise Therapy Focus about any changes that may affect this consent.

Therapy Focus is bound by the *Privacy Act 1988* and undertakes to adhere to the National Privacy Principles.

Please note that Therapy Focus is required to release information about service users to the Disability Services Commission and then without identifying you, to the Australian Institute of Health and Welfare, to enable statistics about disability services and their clients to be compiled. The information will be kept confidential. This information is for statistical purposes only and will not be used to affect your entitlements or your access to services. As a user of CSTDA-funded services you have the right to access your own files and to update or correct information included in the ACDC collection.

SIGNED: _____ DATE: _____

Please send in any reports or information that describe the child's needs, to assist us to check the child's eligibility to access services provided by Therapy Focus, funded by Disability Services Commission.



Person Completing This Form

Name: _____

Relationship to the child: _____

Contact Phone Number: _____

Best time to contact (days/times): _____

Postal Address: _____

Email Address: _____

Please add in the names of anyone you would like to be contacted about this request, e.g., the school principal, the child's teacher, etc.

Name: _____

Relationship to Child: _____

Contact Phone Number: _____

Best time to contact (days/times): _____

Postal Address (if known): _____

Email Address (if known): _____

Thank you for completing this Referral Form. Contact will usually be made with the person referring the child within two weeks of the form being received. However, on occasions a delay may occur. Please feel free to ring our Central Office on the telephone number below if you have not heard from us.

Please return completed Referral Form to:

Therapy Focus Inc

PO Box 20

BENTLEY WA 6982

Phone: (08) 9478 9500 Fax: (08) 9451 5480

Email: enquiries@therapyfocus.org.au

Checklist:

- All sections of this form are completed
- Form is signed & dated
- Reports are attached