Date Received:

*(office use only)*

***Referral Form***

***Child Health and Development Team***

Client Information:

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| This Referral is For: | Community Health Service **OR**  NDIS Service *(please tick one)* | | | | |
| Today’s Date: | | | Child’s Date of Birth: | | |
| Child’s Name: | | | | | Female / Male (please circle) |
| Parents’ / Carers’ Name(s): | | | | | |
| Address: | | | | | Post Code: |
| Phone Number(s): | | Email Address: | | | |
| Country of Birth: | | | | | |
| Language(s) Spoken by Child: | | | | | |
| Language(s) Spoken by Parent(s) / Carer(s): | | | | | |
| Interpreter Needed for Child? Yes / No | | Interpreter Needed for Parent / Carer? Yes / No | | | |
| GP Name: | | | | GP Phone: | |
| GP Address: | | | | | |
| Maternal Child Health Nurse: | | | | | |
| Preschool/Child Care: | | | | Teacher’s Name: | |
| Days Attending: Mon, Tues, Wed, Thurs, Fri (circle all that apply) | | | | | |

What concerns does the parent/carer have about this child’s development?

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What concerns does the referrer (if not parent/carer) have about this child’s development?

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What are this child’s strengths?

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Do you have any concerns about this child’s participation in daily activities?

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| getting ready in the morning: |  |
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| drop-off at childcare or kinder: |  |
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| meal times: |  |
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| play time: |  |
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| going on outings (e.g. to the shops, to playgroup): |  |
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| getting ready for bedtime and sleeping: |  |
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| Who would you like to make a referral to? | | Tick all that apply |
| Dietetics | Dietitians help with fussy eating, over- or underweight children, food allergies and intolerances. |  |
| Occupational Therapy | Occupational Therapists help with self-care skills, motor skills, play skills, school readiness skills, independence and confidence. |  |
| Speech Pathology | Speech Pathologists help with understanding and using spoken language, speech sounds, stuttering, voice, and early literacy skills. |  |

Other Information:

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| Has a referral to NDIS been made? | Yes / No | Please provide details: |
| Has the child had a hearing assessment since birth? | Yes / No | If so, when, where, and results, if know: |
| Has the child seen a Paediatrician? | Yes / No | If yes, please include contact details: |
| Has the child received any previous diagnosis (e.g. Autism, Developmental Delay) | Yes / No | If yes, please include details: |
| Has the child been referred to any other therapists or agencies? | Yes / No | If yes, please include details: |

|  |  |
| --- | --- |
| Referrer’s Name: | Referrer’s Contact Details: |
| Parent / Carer Consent: (please sign) | |

Please send to: Child Health and Development Team Intake, 23 Lennox St, Richmond 3121

**or** intake@nrch.com.au