# Logo  Description automatically generatedCHILD & FAMILY TEAM

# 1624 Burwood Hwy

# Belgrave 3160

**17 Clarke Street**

**Lilydale 3140**

# Ph: 9738 8801

# Fax: 9739 4689

Referral Form

### **CHILD’S NAME: DOB:**

### **PARENT/CARER NAMES**:

**ADDRESS:**

### **TELEPHONE:** **MOBILE:**

Main language spoken at home: Interpreter Required: [ ]  YES [ ]  NO

**Parent/carer HEALTH CARE CARD:** [ ]  YES [ ]  NO *\* see note below*

**Parent/carer consent provided:** [ ]  YES [ ]  NO [ ]  Verbal [ ]  Written

*\* Note: high income families will be charged full fees, and should therefore be encouraged to seek private services*

**1.** **Is the child involved with any other services?** (including private services) [ ]  YES [ ]  NO

If yes, please indicate service type & contact details (e.g. physio, Paediatrician, Anglicare, etc.)

 Phone:

 Phone:

 Phone:

**2.** **Is the child attending:** [ ]  Child-Care / Family Day Care / Playgroup / Other *(please circle)*

 [ ]  Preschool – 3yo / 4yo / repeating *(please circle)*

Name: Contact: Phone:

**3. Within the last 12 months has the child had:**

- A hearing assessment? [ ]  YES [ ]  NO [ ]  UNSURE

Date of Assessment: Results:

*\* Note: all children wishing to access ongoing services from the Child & Family Team require a hearing test within the last 12 months.
Pre-arrangement of this will assist with the referral process.*

- A vision assessment? [ ]  YES [ ]  NO [ ]  UNSURE

Date of Assessment: Results:

Any other specific screening or assessment? [ ]  YES [ ]  NO [ ]  UNSURE

Date of Assessment: Type of Assessment:

Conducted by: Results:

**4.** **Reason for referral** *(please tick all appropriate boxes)*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ***Fine Motor****(e.g. drawing/writing, using scissors, manipulating objects, choosing a dominant hand)* | [ ]  | ***Gross Motor****(e.g. jumping, hopping, balance, ball skills)* | [ ]  | ***Sensory Processing****(e.g. doesn’t like getting hands dirty, under/over responsive to noise, easily over-excited)* | [ ]  |
| ***Speech Sounds****(e.g. unclear / difficult to understand, incorrect production of specific sounds)* | [ ]  | ***Language****(e.g. words out of order, wrong words used, minimal language, difficulty following instructions)* | [ ]  | ***Fluency****(ie. Stuttering)* | [ ]  |
| ***Behaviour****(e.g. non-compliance, tantrums, aggressive, disruptive)* | [ ]  | ***Play Skills****(e.g. limited/inappropriate use of toys, no pretend play, no co-operative play)* | [ ]  | ***Attention/Listening****(e.g. difficulty focussing, easily distracted, fidgety)* | [ ]  |
| ***Self Care/Independence****(e.g. toileting, using cutlery, dressing, tying laces)* | [ ]  | ***Social Skills****(e.g. making friends, turn taking, co-operation, following social rules and non-verbal cues)* | [ ]  | ***Other****(e.g. parenting support, socially isolated, challenging family circumstances)* | [ ]  |

Please describe your concerns:

**5.** Referred By: Organisation:

Address:

Phone: Fax: Email:

Contact required with referrer: [ ]  YES [ ]  NO

Best time(s) to contact: Day(s):

Signature: Date: