Senses Australia
Ending the isolation

School Age Therapy

Referral Form

Child's First Name: _____ Child's Surname: _____

Date of Birth: _____ Gender □ Male □ Female

Address: _____ Postcode: _____

Australian Residency Status: □ Permanent □ Temporary □ Other

Child's Centrelink Number (CRN): _____

Parent(s)/Guardian Details:

Mother's Name: _____ Father's Name: _____

Address: □ as above _____ Postcode: _____

Home Telephone: _____ Mobile: _____

Work Telephone: _____ Email: _____

Main language spoken at home: _____ Interpreter required: □ Yes □ No

Is the child of: □ Aboriginal origin □ Torres Strait Islander origin

□ Both Aboriginal & Torres Strait Islander origin □ Neither

Does the child: □ Live with Family

□ Live with others, provide details:_____

Compensation: □ Are you applying for compensation for your child?

□ Are you already receiving compensation for your child?

Diagnosis:_____

Reason for Referral:

_____

_____

_____

_____

_____

Care and Support Needs (*please tick*)

	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	□	□	□	□
Mobility	□	□	□	□
Communication	□	□	□	□
Interpersonal Relationship	□	□	□	□
Learning	□	□	□	□
Education	□	□	□	□
Community Participation	□	□	□	□

ONLY ANSWER THE FOLLOWING QUESTIONS IF THE CHILD WILL BE 15 YEARS OF AGE OR OLDER BEFORE 1ST JULY				
Domestic Life	□	□	□	□
Working	□	□	□	□
Health Care	□	□	□	□

Do any of the following apply to your child: *(If Yes please describe)*	**√ Tick**
Uses a: ☐wheelchair or ☐walking frame	☐ Yes ☐ No
Requires surgical medical intervention:	☐ Yes ☐ No
Uses a communication device:	☐ Yes ☐ No
Does your child exhibit any of the following? *(If yes, please describe):*	
Aspiration (gagging, choking, or recurrent chest infections):	☐ Yes ☐ No
Difficulty swallowing during mealtimes:	☐ Yes ☐ No
Significant pain or discomfort:	☐ Yes ☐ No
Self-injurious behaviour or behaviour that puts other people at risk:	☐ Yes ☐ No

Services and Agencies Previously/Currently Involved in Care of Child

What other services / agencies are the person registered with or in receipt of?

□ Princess Margaret Hospital □ Other Hospital

*(please specify):*_____

□ DSC □ WAIDE / Deafblind Education

□ Deaf Society □ Association for Blind

□ Child Development Centre *(please specify)*:_____

□ Therapy received *(please describe*):_____

□ Other _____

Family Doctor/GP Name:_____ Location: _____

Specialist Doctor Name: _____Area of Speciality:_____

_____ Area of Speciality:_____

School attending: _____

Current School Year: _____

Details of person completing referral (*if not parent/guardian*)

Referred by: _____ Agency: _____

Telephone: _____ Mobile: _____

Fax: _____ Email: _____

Address:_____

Referee Signature: _____ Date: _____

Parent/Guardian Consent for referral:

Parent's Signature (*or legal guardian if applicable*): Date:

_____ _____

<u>Please ensure you attach the following documentation:</u>

- ☐ **Evidence of Australian Permanent Residency (such as Australian Birth Certificate, Passport or Visa)**
- ☐ **Evidence of Diagnosis (such as report from General Practitioner or Specialist stating diagnosis).**

Consent Form

Authority to Collect, Use and Disclose

Client Information

I…….give authority for Senses Australia;

to collect, use and disclose personal and sensitive information, including health information, for the primary purpose of service provision and directly related needs. Senses Australia will not disclose/ use information about me for any secondary purpose without prior written consent outlining what information is being disclosed, to whom and for what purpose.

Senses Australia will only disclose information held about me:

- to ensure Senses Australia provides and maintains a high level of service provision and meets duty of care obligations;
- for disclosure to a third party eg doctors/specialists;
- to Government Departments such as Disability Services Commission (DSC) to meet Senses Australia contractual obligations, eg, Annual Client Data Collection (ACDC), Standards Monitors;
- to the police, where lawful, and for the purpose of identifying a missing person including a photograph of me.

I understand that Senses Australia only keeps information that is relevant to ensure quality service provision for clients in accordance with *Commonwealth Privacy Amendment (Privacy Sector) Act 2000.*

If there are any changes to be made to this enduring authority, I will notify Senses Australia in writing.

Client's name…….

Signed……. Date……..

Print name……

Where a client does not have the capacity to give informed consent and does not have a legal guardian who has the authority to make decisions on behalf of the client, the client's parent or advocate may sign the Authority to Release Information Form on the client's behalf. The person who signs on the client's behalf must print their relationship to the client next to their name.

Please send completed forms to: **Coordinator of Children's Services**
Email: rebecca.lamhut@senses.org.au
Post: PO Box 143, Burswood, WA, 6100
Ph: (08) 9473 5400 TTY: (08) 9473 5488
Fax: (08) 9473 5499