Occupational Therapy

PAEDIATRIC REFERRAL FORM

Date: _____

Personal Details

Child's Surname: _____ First Name: _____

Date of Birth: _____ Gender: _____

Parent/Guardian Name: _____ Relationship to Child: _____

Address: _____

Suburb: _____ Postcode: _____

Preferred Contact Person: _____

Phone: _____ Email: _____

School: _____

Family Relationships *(siblings, family living with the child)*:

_____

Language/s spoken at home: _____ Interpreter Required: ☐ Yes ☐ No

Person Completing Referral Form: _____

Referral Details

Does your child have: ☐ Medicare Enhanced Primary Care Plan or Team Care Arrangement

☐ Private Health Insurance

NDIS Details

Does the person have an NDIS Plan: ☐ Yes ***(Please include the NDIS Plan to assist with processing of the referral)***

☐ No

How is the NDIS Plan Managed:

☐ **Self-managed**

Person responsible for payment: _____

Phone: _____ Email: _____

Are you able to pay upfront? ☐ Yes ☐ No

☐ **Plan Managed**

Business Name: _____ Contact Name: _____

Phone: _____ Email: _____

☐ **Agency Managed**

☐ **Support Coordinator**

Support Coordinator Name: _____

Phone: _____ Email: _____

General Practitioner

General Practitioner Name: _____

GP Practice: _____

Do you give consent for us to liaise with the GP if necessary: ☐ Yes ☐ No

Please continue to next page

Reason for Referral and Other Information

Please tick if you have concerns regarding any of the following:

- ☐ Attention/Concentration
- ☐ Behaviour/Emotional Regulation
- ☐ Fine Motor Skills
- ☐ Handwriting or Pencil Grasp
- ☐ Self-Care Skills (dressing, toileting, etc.)
- ☐ Sensory Processing
- ☐ Feeding Skills
- ☐ Social/Play Skills
- ☐ Mental Health Concerns
- ☐ Other

What supports do you require in these areas:

Relevant Medical History *(e.g. full term pregnancy, medication, current and previous diagnosis)***:**

Does your child have a history of ear infections? ☐ Yes ☐ No

Has your child's hearing been checked? ☐ Yes ☐ No

If so, what was the result? _____

Has your child's vision been checked? ☐ Yes ☐ No

If so, what was the result? _____

Other service providers involved, including previous therapy *(please provide name)***:**

Any additional information that you feel is relevant to this referral:

Please return this completed form, a copy of the NDIS plan and any other relevant documentation to Amity Health via one of the following methods:

Email: query@amityhealth.com.au

Fax: 9842 2798

Amity Health will contact you as soon as possible to discuss your referral.
For more information please visit our website www.amityhealth.com.au or contact Amity Health on 9842 2797