Occupational Therapy and Speech Pathology

PAEDIATRIC REFERRAL FORM

Date: _____

Personal Details

Childs Name: _____ Date of Birth: __/__/__ Gender: _____

Parent/Guardian Name: _____ Relationship to Child: _____

Address: _____

Suburb: _____ Postcode: _____

Preferred Contact Name: _____

Phone: _____ Email: _____

School: _____

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

_____

Person Completing Referral Form: _____

COVID-19 Vaccination Status: ☐ 1st Dose ☐ 2nd Dose ☐ Booster

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

Allied Health Service Required

☐ Occupational Therapist ☐ Speech Pathologist

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
- ☐ Early Language Development (vocalising, babbling, non-verbal communication)
- ☐ Early Learning Skills
- ☐ Comprehension (understanding language and following instructions
- ☐ Stuttering
- ☐ Oral Language and Expression (sentence construction and length, vocab, grammar)
- ☐ Speech Sounds
- ☐ Pre-Literacy (letter and sound knowledge)
- ☐ Literacy (reading and writing)
- ☐ Other

Please describe the above concerns in further detail:

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:

Post: PO Box 5294, ALBANY WA 6332

Fax: 9842 2798

Email: query@amityhealth.com.au

Thank you for your referral. 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

Head Office: 136 Lockyer Avenue Albany WA 6330 | PO Box 5294 Albany WA 6332
Wheatbelt Offices: Merredin, Moora, Narrogin, Northam South-East Coastal Goldfields Office : Esperance
t: (08) 9842 2797 f: (08) 9842 2798 e: query@amityhealth.com.au www.amityhealth.com.au