# 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: ______________________________________

### Referral Details

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

### NDIS Details

Does your child have an NDIS Plan: ☐ Yes ☐ No

How is the NDIS Plan Managed:

☐ **Self-managed**

Person responsible for payment: ______________________________________

Phone: ____________________________________________________________

Are you able to pay upfront? ☐ Yes ☐ No

☐ **Plan Managed**

Plan Manager Name: ______________________________________________

Phone: ____________________________________________________________

☐ **Agency Managed**

☐ **Support Coordinator**

Support Coordinator Name: ______________________________________

Phone: ____________________________________________________________

***Please note we require a copy of the NDIS Plan before acceptance of the referral***

### 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 | ☐ | Early Language Development (vocalising, babbling, non-verbal communication) |
| ☐ | Behaviour/Emotional Regulation | ☐ | Early Learning Skills |
| ☐ | Fine Motor Skills | ☐ | Comprehension (understanding language and following instructions |
| ☐ | Handwriting or Pencil Grasp | ☐ | Stuttering |
| ☐ | Self-Care Skills (dressing, toileting, etc.) | ☐ | Oral Language and Expression (sentence construction and length, vocab, grammar) |
| ☐ | Sensory Processing | ☐ | Speech Sounds |
| ☐ | Feeding Skills | ☐ | Pre-Literacy (letter and sound knowledge) |
| ☐ | Social/Play Skills | ☐ | Literacy (reading and writing) |
| ☐ | Mental Health Concerns | ☐ | 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**