

Date completed: ___/___/_____	Received via: <input type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/> Post <input type="checkbox"/> In person Referred from: <input type="checkbox"/> Parent/Legal Guardian <input type="checkbox"/> Other
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Please indicate the Service required for your child's referral: **ALLIED HEALTH** **NDIS** **UNKNOWN**
If you are unsure which is required, please call your local BUSHkids Centre to discuss our Service areas.

Details of CHILD being referred

Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female First Name/s: _____ Surname: _____ Date of Birth: ___/___/_____ Address: _____ Suburb: _____ Postcode: _____ Australian Citizen/Permanent Resident? <input type="checkbox"/> Y <input type="checkbox"/> N Visa type (if applicable): _____	Culturally/Linguistically Diverse Background: <input type="checkbox"/> Yes <input type="checkbox"/> No Please state Country of Birth: _____ Language/s Spoken at home: _____ Do you require an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the child identify as: <input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> South Sea Islander <input type="checkbox"/> Both Aboriginal and Torres Strait Islander <input type="checkbox"/> Non-Indigenous <input type="checkbox"/> Other: _____
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PARENT/LEGAL GUARDIAN (Primary) details

First Name/s: _____ Surname: _____ Date of Birth: ___/___/_____ Address: _____ Suburb: _____ Postcode: _____ Email: _____ _____	Relationship to child: _____ Occupation: _____ Preferred method of contact: <input type="checkbox"/> Phone <input type="checkbox"/> SMS <input type="checkbox"/> Email <input type="checkbox"/> Post Mobile: _____ Home: _____ Work: _____
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Who does the child live with? Mother Father Both Other: _____
 If other please provided details: _____

Does your child attend school/playgroup: Not attending Playgroup Childcare Kindergarten School
 Does your Child receive assistance where attending? Yes No
 Name of School/Childcare/Playgroup: _____

Has your child received a diagnosis of any disorder, disability or syndrome?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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If yes please provided details:

Has your child had any previous assessments? (e.g. speech, child development services)		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, provide details:			
Is your child currently linked with any therapist/s or specialist services?			
<input type="checkbox"/> Speech therapy <input type="checkbox"/> Occupational therapy <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Paediatrician/Medical Specialists		<input type="checkbox"/> Child Development Service (CDS) <input type="checkbox"/> Community Health / Child Health <input type="checkbox"/> Child Youth Mental Health Service (CYMHS) <input type="checkbox"/> Other	
If yes, please provide more information:			
Organisation	Contact Name	Profession	Frequency of visits
Please advise which areas of development you are concerned about:			
Language and Communication <i>(e.g. speech easily understood by others, putting words together to form sentences, understanding what is being said)</i>			
<input type="checkbox"/> Priority area of concern		<input type="checkbox"/> Secondary area of concern	<input type="checkbox"/> No concerns
Fine Motor Development <i>(e.g. picking up and manipulating items well, using two hands together, holding a pencil correctly, drawing, using scissors)</i>			
<input type="checkbox"/> Priority area of concern		<input type="checkbox"/> Secondary area of concern	<input type="checkbox"/> No concerns
Gross Motor Development <i>(e.g. posture, core strength, crawling, walking, running, jumping and hopping in a coordinated way, climbing, balancing)</i>			
<input type="checkbox"/> Priority area of concern		<input type="checkbox"/> Secondary area of concern	<input type="checkbox"/> No concerns
Cognitive Development <i>(e.g. following instructions, playing, puzzles, building with blocks, reading and writing appropriately for age)</i>			
<input type="checkbox"/> Priority area of concern		<input type="checkbox"/> Secondary area of concern	<input type="checkbox"/> No concerns
Self-Care Skills <i>(e.g. dressing, toileting, eating, drinking, bathing and sleeping)</i>			
<input type="checkbox"/> Priority area of concern		<input type="checkbox"/> Secondary area of concern	<input type="checkbox"/> No concerns
Social-Emotional Skills/Behaviour concerns <i>(e.g. making friends, sharing, taking turns, difficult behaviours, attention and concentration)</i>			
<input type="checkbox"/> Priority area of concern		<input type="checkbox"/> Secondary area of concern	<input type="checkbox"/> No concerns

Is there anything additional about your child's development or your family circumstances that you would like BUSHkids to know?

What support would you like from BUSHkids for your child?

- Support to access the National Disability Insurance Scheme (if eligible).
- Short-term intervention with an allied health professional / early intervention facilitator.
- Assistance to link with appropriate community services and supports.
- Transition to school support for 2020.
- Unsure at this time.

PARENT/LEGAL GUARDIAN CONSENT

- I give consent to this referral
- I give permission for the exchange of information between BUSHkids staff and other professionals relevant to this referral
- If applicable, I give permission for BUSHkids to share my personal information with the National Disability Insurance Agency (NDIA) including recording this information in the National Disability Insurance Scheme database.

Name: _____ Parent Legal Guardian

Signed: _____ Date: ____/____/____

Form completed by Referrer, e.g. teacher, GP, etc Date: ____/____/____

Referrer Name: _____ Contact Number: _____

Organisation: _____ Address: _____

- Verbal consent obtained from the parent/legal guardian for this referral
- Verbal consent obtained from the parent/legal guardian for the exchange of information between BUSHkids staff and other professionals relevant to this referral
- Verbal consent obtained from the parent/legal guardian for permission to share personal information with the National Disability Insurance Agency (NDIA) including recording this information in the National Disability Insurance Scheme database if applicable to this referral.

Please return completed form via post or email to your local BUSHkids Centre.

BUSHkids contact details are available at www.bushkids.org.au/contact
Once the form is received/processed, a BUSHkids staff member will contact you.

OFFICE USE ONLY

Form completed by parent/legal guardian and received by: _____ Date: _____

Staff Name: _____ Position: _____

Form completed via phone with parent/legal guardian by: _____ Date: _____

Staff Name: _____ Position: _____

- Verbal consent obtained from the parent/legal guardian for this referral
- Verbal consent obtained from the parent/legal guardian for the exchange of information between BUSHkids staff and other professionals relevant to this referral
- Verbal consent obtained from the parent/legal guardian for permission to share personal information with the National Disability Insurance Agency (NDIA) including recording this information in the National Disability Insurance Scheme database if applicable to this referral.

Information Provided at time of referral? Yes No

Details: _____

Linkage to Community Provided at time of referral? Yes No

Details: _____