

CHILDREN AND YOUTH SERVICES

REFERRAL FORM

Therapy Focus is a not-for-profit community organisation which provides therapy services for individuals with a disability or learning disadvantage.

Therapy Focus' Children and Youth Services (CAYS) division delivers West Australian State Government funded therapy services within the communities that children live in on a day to day basis (for example home, kindy, pre-school, school, after school groups).

Through close collaboration with key people in a child's life, such as parents, carers and school staff, therapists can embed therapy goals into daily routines. There is a need for parents, carers and school staff to be willing to support therapy programmes in order for the child to gain the most from services offered by Therapy Focus.

Individuals who meet eligibility criteria can access CAYS therapy and support services which can include:

- Occupational Therapy
- Physiotherapy
- Speech Pathology
- Specialised aids and equipment
- Community groups and activities

To access CAYS services, a child must meet the following three criteria:

1. Be a permanent resident of Australia
2. Be aged between 0 -18 years
3. Have physical, social and/or communication needs which limit their ability to participate in home, community and school life.

And for children not yet starting year one:

- Live in the Metropolitan area or Mandurah/ Peel region
- Have a disability or a delay in development

And for a child who is currently enrolled in year one or above at school

- Attend school (including home school) in the West Coast, Swan, Swan-Sub or Canning Department of Education districts
- Be enrolled in a full time schooling program
- Have an intellectual, physical, neurological or cognitive disability that is permanent or likely to be permanent

Children attending a Language Development School or Sir David Brand Education Support School are not eligible for CAYS services. Children with Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) or Mental Health illness are not eligible for CAYS services unless they have another disability that meets the eligibility requirements.

Please consider the needs of the client carefully before completing the referral form.

Child Details

First Name:		Family Name:	
Date of Birth:		Child's Sex:	<input type="checkbox"/> F <input type="checkbox"/> M
Country of Birth:			
Australian Residency Status:	<input type="checkbox"/> Permanent	<input type="checkbox"/> Temporary	<input type="checkbox"/> Other
If you have ticked Other please give details: _____			

Does the child require interpreter services?	<input type="checkbox"/> Yes <input type="checkbox"/> No
What is the main language spoken in the child's home?	
What is the child's <i>most</i> effective method of communication?	√ Tick ONE only
Uses speech to say what they want	<input type="checkbox"/>
Uses sign language to say what they want	<input type="checkbox"/>
Uses a communication device to say what they want (e.g. Canon Communicator, Compic)	<input type="checkbox"/>
Little or no effective communication	<input type="checkbox"/>
Child under 5 years old	<input type="checkbox"/>

Is the child of:	√ Tick ONE only
Aboriginal but not Torres Strait Islander origin	<input type="checkbox"/>
Torres Strait Islander but not Aboriginal origin	<input type="checkbox"/>
Both Aboriginal and Torres Strait Islander origin	<input type="checkbox"/>
Neither Aboriginal nor Torres Strait Islander origin	<input type="checkbox"/>

Does the child:	√ Tick ONE only
Live alone	<input type="checkbox"/>
Live with Family	<input type="checkbox"/>
Live with others (<i>please give details of who the child lives with</i>):	<input type="checkbox"/>

Residential setting:	√ Tick ONE only
Private residence	<input type="checkbox"/>
Residence within an Aboriginal/Torres Strait Islander community	<input type="checkbox"/>
<i>Group homes (i.e., less than 7 people and 24-hour supervision/care)</i>	<input type="checkbox"/>
<i>Hostels (i.e., 7 or more people and 24-hour supervision/care)</i>	<input type="checkbox"/>
Short term crisis accommodation or transitional accommodation	<input type="checkbox"/>
Other: <i>Please give details of other accommodation arrangements</i>	<input type="checkbox"/>

Compensation related to the child's disability: – if applicable	√ Tick
Are you applying for compensation for the child?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you currently receiving compensation on behalf of the child?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes to either of the above, please provide name, address and contact details of the Insurance Agency, Case Manager and/or the Solicitor.	

Only answer the following question if the child is <u>16</u> years of age or older	
Does your child receive Disability Support Pension (If ticked yes please provide the child's Centrelink No): _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Primary Contact

Parent/Guardian Details			
First Name:		Family Name:	
Relationship to the child:			
Address			
Suburb:		Postcode:	
Home Phone:		Work Phone:	
Mobile:		Email:	
Spoken Language		Interpreter Required?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Alternative Contact (when we cannot contact the Parent/Guardian)

First Name:		Family Name:	
Relationship with the child:			
Home Phone:		Work Phone:	
Mobile:		Email:	
Spoken Language		Interpreter Required?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Details of Primary Carer

(Collected for statistical purposes as required by the Federal Government)

Is the child cared for by a paid person or an unpaid person arranged through a service provider?		<input type="checkbox"/> Yes (Please skip this section and move to the next) <input type="checkbox"/> No (Please continue)	
What is the relationship of the carer to this child?	<input type="checkbox"/> Mother	<input type="checkbox"/> Other female relative	<input type="checkbox"/> Female friend/neighbour
	<input type="checkbox"/> Father	<input type="checkbox"/> Other male relative	<input type="checkbox"/> Male friend/neighbour
Does the carer live in the same household as the child?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If the child is under 16, does the carer receive Carer's Allowance from Centrelink for the child:			<input type="checkbox"/> Yes <input type="checkbox"/> No
If YES please provide the Centrelink Number:			
What age group does the Carer fit into?			
<input type="checkbox"/> 15-24 years	<input type="checkbox"/> 25-44 years	<input type="checkbox"/> 45-64 years	<input type="checkbox"/> 65 years and over
Does the carer assist the child in area(s) of self-care, mobility or communication?			<input type="checkbox"/> Yes <input type="checkbox"/> No

Community Participation

What is the child's usual day activity? (you may tick more than one box):		
<input type="checkbox"/> No formal day activity	<input type="checkbox"/> Kindergarten	<input type="checkbox"/> Education Support Centre
<input type="checkbox"/> Day Care	<input type="checkbox"/> Pre-school	<input type="checkbox"/> Education Support School
<input type="checkbox"/> Child Care	<input type="checkbox"/> Home School	<input type="checkbox"/> School

School/Child Care Centre Information			
Name of School/Centre:			
Address:			
Suburb:		Postcode:	
Telephone Number:			
Teacher's Name:		Current School Year:	
Is the child changing schools/child care in the next 12 months?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If Yes , what date: _____ Name of new School/Centre: _____			

Disability

- 1. Please show the child's main disability by ticking one box only against Primary Disability.**
2. Tick all other significant disabilities in the column headed Other Significant.

TYPE OF DISABILITY	Primary Disability √ Tick ONE box only	Other Significant √ Tick as many as apply
1. Cognitive or Learning Disability ♂		
Acquired brain injury ¹	<input type="checkbox"/>	<input type="checkbox"/>
Specific learning (<i>other than Intellectual</i>) ²	<input type="checkbox"/>	<input type="checkbox"/>
Attention Deficit Disorder ^{2.1}	<input type="checkbox"/>	<input type="checkbox"/>
2. Intellectual Disability		
Developmental delay (<i>applies to 0-5 year olds only</i>) ⁴	<input type="checkbox"/>	<input type="checkbox"/>
Intellectual Disability (<i>including Down Syndrome</i>) ⁵	<input type="checkbox"/>	<input type="checkbox"/>
3. Autism Spectrum Disorder		
Asperger's Syndrome ³	<input type="checkbox"/>	<input type="checkbox"/>
Autism ³	<input type="checkbox"/>	<input type="checkbox"/>
PDD ³	<input type="checkbox"/>	<input type="checkbox"/>
4. Neurological Disability		
Multiple Sclerosis ⁶	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy ⁷	<input type="checkbox"/>	<input type="checkbox"/>
OTHER Neurological ⁷ (please specify): _____	<input type="checkbox"/>	<input type="checkbox"/>
5. Physical Disability		
Cerebral Palsy ⁸	<input type="checkbox"/>	<input type="checkbox"/>
Motor Neurone Disease ⁹	<input type="checkbox"/>	<input type="checkbox"/>
Muscular Dystrophy ¹⁰	<input type="checkbox"/>	<input type="checkbox"/>
Para/Quadri/Tetra Hemiplegia ¹¹	<input type="checkbox"/>	<input type="checkbox"/>
Spina Bifida ¹²	<input type="checkbox"/>	<input type="checkbox"/>
OTHER Physical ¹³ (please specify): _____	<input type="checkbox"/>	<input type="checkbox"/>
6. Sensory Disability		
Deafblind (<i>dual sensory</i>) ¹⁵	<input type="checkbox"/>	<input type="checkbox"/>
Blind/Vision (<i>sensory</i>) ¹⁶	<input type="checkbox"/>	<input type="checkbox"/>
Deaf/Hearing (<i>sensory</i>) ¹⁷	<input type="checkbox"/>	<input type="checkbox"/>
Non Verbal/Speech Impairment ¹⁸	<input type="checkbox"/>	<input type="checkbox"/>
7. Psychiatric ¹⁴ (please specify): _____	<input type="checkbox"/>	<input type="checkbox"/>
8. Other Disability ¹⁹ (please specify): _____	<input type="checkbox"/>	<input type="checkbox"/>
Please provide medical or psychologist report to confirm the child's disability.		

Health and Behaviour

Is the child currently experiencing any of the following health concerns:	√ Tick
• aspiration (gagging, choking, or recurrent chest infections)	<input type="checkbox"/> Yes <input type="checkbox"/> No
• excessive weight gain or loss	<input type="checkbox"/> Yes <input type="checkbox"/> No
• pressure sores	<input type="checkbox"/> Yes <input type="checkbox"/> No
• significant pain or discomfort	<input type="checkbox"/> Yes <input type="checkbox"/> No
• tracheostomy	<input type="checkbox"/> Yes <input type="checkbox"/> No
• suctioning and/or oxygen therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No
• urinary catheter or stoma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other relevant health information not described above:	
Please provide report from medical/health personnel detailing any of the above concerns.	
Does your child exhibit any of the following behaviours? If yes, please describe:	
Self injury behaviours (e.g. biting/hitting self, head banging)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Aggression towards other people	<input type="checkbox"/> Yes <input type="checkbox"/> No
A lack of awareness of potential danger in their environment e.g. running onto a road.	<input type="checkbox"/> Yes <input type="checkbox"/> No

Services and Agencies Involved in care of the child in the <u>last three years</u>	
Princess Margaret Hospital:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other Hospital:	<input type="checkbox"/> Yes <input type="checkbox"/> No (Hospital Name) _____
Child Development Centre:	<input type="checkbox"/> Yes <input type="checkbox"/> No (Name of CDC) _____
Received therapy in the <u>last three years</u>? <input type="checkbox"/> Yes <input type="checkbox"/> No (Please provide details)	
Are you currently waitlisted with other service providers? (e.g. DSC, Autism Association, The Centre for Cerebral Palsy, Senses)	<input type="checkbox"/> No <input type="checkbox"/> Yes (Please provide details)
Agencies currently providing care to your child (e.g. Autism Association, Department of Child Protection, LAC and other therapy service providers)	<input type="checkbox"/> No <input type="checkbox"/> Yes (Please provide details)
Name of Family Doctor/GP:	Name of Specialist Doctor/s:

Help or Supervision

Tick one box in each area that best describes the child's need for help or supervision.

For example: Under **Self Care** - if the child *always needs help* with dressing, requires *occasional supervision* in toileting but is able to do washing and eating independently.

You would select "**Always needs help/supervision**", which is the highest level of need for that area.

		Always needs help/ supervision	Sometimes needs help/ supervision	Does not need help but uses aids/equipment	Does not need help or use aids/ equipment
For all children	Self Care: <ul style="list-style-type: none"> • Washing • Dressing • Eating • Toileting 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Please describe help/equipment needed:				
	Mobility <ul style="list-style-type: none"> • Walking on level ground, up/down steps • Getting in/out of a bed or a chair • Transport - private and/or public 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Please describe help/equipment needed:				
Communication: <ul style="list-style-type: none"> • Making themselves understood • Understanding others 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Please describe help/equipment needed:					
Interpersonal Relationships: <ul style="list-style-type: none"> • Making and keeps friends • Behaving acceptable ways • Coping with feelings 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Please describe help/equipment needed:					

Please send in any reports or information describing the child's needs.

		Always needs help/supervision	Sometimes needs help/supervision	Does not need help but uses aids/equipment	Does not need help or use aids/equipment
For children who will be <u>5</u> years of age or older before July 1st	Learning: <ul style="list-style-type: none"> Understanding new ideas Ability to remember, solve problems, make decisions Ability to pay attention Ability to do single or multiple tasks Ability to carry out daily routines 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Please describe help/equipment needed:				
	Education: <ul style="list-style-type: none"> Handling tasks required at school 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please describe help/equipment needed:					
For children who will be <u>15</u> years of age or older before July 1st	Community Participation: <ul style="list-style-type: none"> Engagement in recreation and leisure activities Handling money Shopping 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Please describe help/equipment needed:				
	Domestic Life <ul style="list-style-type: none"> Making meals Cleaning Cooking Shopping 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please describe help/equipment needed:					
For children who will be <u>15</u> years of age or older before July 1st	Work skills <ul style="list-style-type: none"> Work experience Part time work Voluntary work experience School based work skills training 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Please describe help/equipment needed:				
	Health Care <ul style="list-style-type: none"> Engagement in exercises Taking medication 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please describe help/equipment needed:					
Please send in any reports or information describing the child's needs.					

Parent/Guardian Consent

I _____ (Parent / Guardian) of _____
 (First Name) (Family Name) Please circle as appropriate
 _____ (Child's Name)

hereby give Therapy Focus consent to access reports and information regarding the child so Therapy Focus can assess if he/she is eligible to receive services.

These may include:

- Psychological Reports
- Medical Reports
- Therapy Reports
- Educational Reports
- Other Reports

I give consent for Therapy Focus to work with the child and for:	
<ul style="list-style-type: none"> • the child to receive services from a student working under the supervision of a Therapy Focus staff member 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<ul style="list-style-type: none"> • Therapy Focus to share information about the child with: <ul style="list-style-type: none"> • School authority • Medical or Therapy personnel • Other (please specify): _____ _____ 	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
<ul style="list-style-type: none"> • Therapy Focus to photograph or video the therapy session/s provided to the child for use in therapy 	<input type="checkbox"/> Yes <input type="checkbox"/> No

I understand this consent will stay in place while the child is receiving services from Therapy Focus. I agree to advise Therapy Focus about any changes that may affect this consent.

Therapy Focus is bound by the *Privacy Act 1988* and undertakes to adhere to the National Privacy Principles.

I understand that Therapy Focus is required to release information about service users to the Disability Services Commission and then without identifying the service user, to the Australian Institute of Health and Welfare, to enable statistics about disability services and their clients to be compiled. The information will be kept confidential. This information is for statistical purposes only and will not be used to affect our entitlements or our access to services. As a user of Commonwealth State/Territory Disability Agreement (CSTDA) funded services I have the right to access the child's files and to update or correct information included in the Annual Client and Service Data Collection (ACDC).

SIGNED: _____ **DATE:** _____

Person Completing This Form

Name: _____

Relationship to the child: _____

Contact Phone Number: _____

Best time to contact (days/times): _____

Postal Address: _____

Email Address: _____

Please add in the names of anyone you would like to be contacted about this request, e.g. the school principal, the child's teacher, etc.

Name: _____

Relationship to Child: _____

Contact Phone Number: _____

Best time to contact (days/times): _____

Postal Address (if known): _____

Email Address (if known): _____

Thank you for completing this Referral Form. Contact will usually be made with the person referring the child within two weeks of the form being received. However, on occasions a delay may occur. Please feel free to ring our Central Office on the telephone number below if you have not heard from us.

Please return completed Referral Form to:

Therapy Focus Inc

PO Box 20

BENTLEY WA 6982

Phone: (08) 9478 9500 Fax: (08) 9451 5480

Email: enquiries@therapyfocus.org.au**Checklist:**

- All sections of this form are completed
- Form is signed & dated
- Reports are attached