Therapy Services Referral Form

Personal details of the client being referred

SURNAME: ______________________ FIRST NAME: ______________________

Date of Birth: ______________________ Gender: Male ☐ Female ☐

Email: ______________________

Address: ______________________ P/code: __________

Home Phone: __________ Mob: __________ BH: __________

Australian Residency Status

☐ Citizen ☐ Permanent Resident ☐ Visa (provide details) ______________________

Parent/Guardian/Person Responsible details:

Relationship: Parent ☐ Guardian ☐ Foster Parent ☐ Other ☐ __________

Name: ______________________

Email: ______________________

Address (if different from client's): ______________________ P/code: __________

Home Phone: __________ Mob: __________ BH: __________

Is the client aware of the referral: Yes ☐ No ☐

If the referral is for a child, are there any Court Orders or Parenting Orders in place?

Yes ☐ No ☐

If YES, please provide details of the arrangement(s):

Does the person or person's parent/guardian require an interpreter? Yes ☐ No ☐

If YES, what language? ______________________

I'd like to make a referral for:

☐ Speech Pathology
☐ Occupational Therapy
☐ Physiotherapy
☐ Psychology
☐ Behaviour Support (North only)
☐ Unsure

Therapy History

Has the person being referred ever received:

Physiotherapy Yes ☐ No ☐

If **YES**, who provided the service?

When? From: ______________ To: ______________

Speech Pathology Yes ☐ No ☐

If **YES**, who provided the service?

When? From: ______________ To: ______________

Occupational Therapy Yes ☐ No ☐

If **YES**, who provided the service?

When? From: ______________ To: ______________

Psychology Yes ☐ No ☐

If **YES**, who provided the service?

When? From: ______________ To: ______________

Name of other agencies/professionals:

Describe the person's strengths:

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Please describe your concerns; for instance: Gross / Fine motor, Sensory / Attention, Speech language / Feeding, Cognitive / Behaviour, Social / Emotional, Seating, Support with accessing technology / Communication devices

Provide any relevant history that may be impacting on your concerns

(Please attach or provide any additional information to assist us to determine an appropriate service option)

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(If applicable) What school/day service does the person being referred attend?

Funding being utilised to access the services:

please tick all relevant

- NDIS (NDIS #) ______ ☐
- Helping children with Autism: ☐
  (Provide a copy of your Letter of Introduction)
- Better Start ☐
  (Provide a copy of your Letter of Introduction)
- Medicare ☐
  (Referral must be made by your GP or Paediatrician/Specialist outlining the Medicare Service being requested)
- Public: ☐
- Private Health Insurance ☐
- MAIB (Claim #) ______ ☐
- Workers Compensation ☐
- DVA ☐

Referring Agent

Name: ______

Position and Organisation: ______

Address: ______ State: ______ P/code: ______

Email: ______

Phone: ______ Mob: ______

Return to:
StGiles
PO Box 416
Launceston TAS 7250

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Fax: + 61 3 6345 7373