

**SENSES FOUNDATION**

11 Kitchener Ave, Burswood WA 6100 / PO Box 143, Burswood WA 6100  
PHONE - VOICE (08) 9473 5400 TTY (08) 9473 5488 FAX (08) 9473 5499



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**Deafblind Statewide Consultation Program  
- Referral Form -**

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**Client Details**

First Name: \_\_\_\_\_ Surname: \_\_\_\_\_

DOB: \_\_\_\_\_ Address: \_\_\_\_\_ Postcode: \_\_\_\_\_

Australian Residency Status:  Permanent  Temporary  Other

Parents/Guardians Details

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Address:  as above \_\_\_\_\_ Postcode: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Mobile: \_\_\_\_\_

Work Telephone: \_\_\_\_\_

Email: \_\_\_\_\_

Main language spoken at home: \_\_\_\_\_ Interpreter required:  Yes  No

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**Referral Details**

Referred by: \_\_\_\_\_

Agency: \_\_\_\_\_

Telephone: \_\_\_\_\_ Mobile: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

Diagnosis (*if applicable*): \_\_\_\_\_

Reason for Referral: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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## Services and Agencies Previously/Currently Involved in Care of Client

What other services / agencies are the person registered with or in receipt of?

- Princess Margaret Hospital       Other Hospital (*please Specify*): \_\_\_\_\_
- DSC
- WAIDE / DeafBlind Education
- Carson St School
- Deaf Society
- Association for Blind
- The Centre for Cerebral Palsy
- Rocky Bay
- Child Development Centre (*please specify*): \_\_\_\_\_
- Other \_\_\_\_\_

Family Doctor/GP Name: \_\_\_\_\_ Location: \_\_\_\_\_

Specialist Doctor Name: \_\_\_\_\_ Area of Speciality: \_\_\_\_\_

\_\_\_\_\_ Area of Speciality: \_\_\_\_\_

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Parents Signature: \_\_\_\_\_ (or legal guardian if applicable)

Referee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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### Office Use Only

Eligible for services?     Yes       No

Program Manager Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Comments: \_\_\_\_\_

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