
School Age Therapy Services Referral Form

Client Details

Child's First Name: _____ Child's Surname: _____
DOB: _____ Address: _____ Postcode: _____
Australian Residency Status: Permanent Temporary Other
Child's Centrelink Number: _____
Child's DSC File Number: _____

Parent/Guardian Details

Mother's Name: _____ Father's Name: _____
Address: as above _____ Postcode: _____
Home Telephone: _____ Mobile: _____
Work Telephone: _____ Email: _____

Would you like Senses to email you regarding community resources and/or events? Yes No

Main language spoken at home: _____ Interpreter required: Yes No

Guardian details (if applicable): _____

Is the child of: Aboriginal origin
 Torres Strait Islander origin
 Both Aboriginal & Torres Strait Islander origin
 Neither

Does the child: Live with Family
 Live with others (details: _____)

Compensation: Are you applying for compensation for your child?
 Are you already receiving compensation for your child?

Diagnosis of child: _____

What do you consider your child's strengths?

What do you consider your child's area(s) of difficulty?

Care and Support Needs

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

	Always needs help or supervision	Sometimes needs help or supervision	Does not need help but uses aids or equipment	Does not need help and does not use aids or equipment
Self Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mobility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interpersonal Relationship	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ONLY ANSWER THE FOLLOWING QUESTIONS IN THE CHILD WILL BE 5 YEARS OF AGE OR OLDER BEFORE 1ST JULY				
Learning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Community Participation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ONLY ANSWER THE FOLLOING QUESTIONS IF THE CHILD WILL BE 15 YEARS OF AGE OR OLDER BEFORE 1ST JULY				
Domestic Life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Working	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Does your child *(please tick if relevant)*:

- use a wheelchair or walking frame?
 - use a communication device?
 - have difficulty swallowing during mealtimes?
 - require surgical medical intervention?
-

School Information

Name of School / Centre: _____

Address: _____

Telephone: _____ Fax: _____

Teachers Name: _____

Current School Year: _____

Services and Agencies Previously/Currently Involved in Care of Child

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

Princess Margaret Hospital Other Hospital (*please Specify*): _____

Disability Services Commission Autism Association Association for Blind

The Centre for Cerebral Palsy Rocky Bay Vision Education

WAIDE / DeafBlind Education Centre for Inclusive Schooling

Therapy Focus

Child Development Centre (*please specify*): _____

Other _____

Local Area Coordinator: (*name*) _____

Family Doctor/GP Name: _____ Location: _____

Specialist Doctor Name: _____ Area of Speciality: _____

_____ Area of Speciality: _____

Referring Person (*if not parents/guardian*)

Referrer's Name: _____ Phone: _____

Referrer's Agency: _____ Fax: _____

Email: _____ Date: _____

Parent/Guardian Consent

I consent for my child to receive services from Senses Foundation

Parent's Signature: _____ Date: _____

(or legal guardian if applicable)

Office Use Only

Eligible for services? Yes No

Program Manager Signature: _____ Date: _____

Comments: _____



SENSES FOUNDATION

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AUTHORITY TO COLLECT, USE AND DISCLOSE CLIENT INFORMATION

I.....give authority for Senses Foundation;

to collect, use and disclose personal and sensitive information, including health information, for the primary purpose of service provision and directly related needs. Senses Foundation will not disclose/ use information about me for any secondary purpose without prior written consent outlining what information is being disclosed, to whom and for what purpose.

Senses Foundation will only disclose information held about me:

- to ensure Senses Foundation provides and maintains a high level of service provision and meets duty of care obligations;
- for disclosure to a third party eg doctors/specialists;
- to Government Departments such as Disability Services Commission (DSC) to meet Senses Foundation contractual obligations, eg, Annual Client Data Collection (ACDC), Standards Monitors;
- to the police, where lawful, and for the purpose of identifying a missing person including a photograph of me.

I understand that Senses Foundation only keeps information that is relevant to ensure quality service provision for clients in accordance with *Commonwealth Privacy Amendment (Privacy Sector) Act 2000*.

If there are any changes to be made to this enduring authority, I will notify Senses Foundation in writing.

Client's name.....

Signed.....Date.....

Print name.....

Where a client does not have the capacity to give informed consent and does not have a legal guardian who has the authority to make decisions on behalf of the client, the client's parent or advocate may sign the Authority to Release Information Form on the client's behalf. The person who signs on the client's behalf must print their relationship to the client next to their name.