Can:Do 4 Kids

REFERRAL FORM – INITIAL

This form is to be used where the child/young person is not an existing client of CanDo4Kids

Child / Young Adult

Name: ……..…… …… **Date of Birth:**……/……/……

Address:…… **M** ☐ **F** ☐

…… **School:** ……..

…….. **PC** ……..… **Year:** ……. **DECS** ☐ **Catholic** ☐ **Ind.** ☐

Nature of sensory impairment: **Vision** ☐ **Hearing** ☐ **(Deafblind) Dual sensory** ☐

Diagnosis: ……..

Is the primary disability sensory? **Yes** ☐ **No** ☐

If No, what is the primary disability of the child / young adult:

- ☐ Physical
- ☐ Development Delay (0-5yrs. only)
- ☐ Acquired Brain Injury
- ☐ Autism, including Asperger's syndrome
- ☐ Intellectual disability
- ☐ Speech impairment
- ☐ Neurological (eg. Epilepsy)

Other Organisation involved for primary disability **Contact Person / Contact Number**

…… ……

…… ……..

Parent/Caregiver	**Parent/Caregiver**
Name(s): ……..	……
Relationship: ……..	……
Address: ……..	……
……PC…….	…… …PC…….
Phone Number: (H)……..	(H)……..
(Mob) ……..…… (W)……	(Mob)…… (W) ……
Email: ……	……..……

Name of person referring: ……..…… Date of referral: ……

Organisation: …….. Contact Phone Number: ……..……

Contact Address: ……

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PTO

Specific Service Requested

- ☐ **Early Intervention**
- ☐ **Occupational Therapy**
- ☐ **Speech Therapy**
- ☐ **Child & Youth**
- ☐ **Assistive Technology**
- ☐ **Feeding Support**
- ☐ **Orientation & Mobility**
- ☐ **Auditory Processing Disorder Therapy**
- ☐ **Social Work**

Reason for referral: Please describe the child's / student's needs

……..

……..

……..

……..

I consent to this referral and to CanDo4Kids Community Services staff contacting those named on the form to share further information regarding support needs.

Parent / Caregiver's Name: ……..

Signature: ……..**Date:**……

<u>Please note</u>: Before a service is offered Can:Do 4Kids will follow a process to determine eligibility, appropriateness and whether resources are available to provide the service requested.
You will be informed of the outcome when the referral process has been completed.

<u>OFFICE USE ONLY</u>

Referral received by:……..…… Passed to ……..…… Referral received Date: ……./……./…….

Processed by Referral Coordinator: ……. …….. Date:……/…..…/……
Name Signature

Initial Appointment date: ……../……./…… Assessment completed by:……

☐ Applicant meets client eligibility criteria. Service Provider is: …… …/…./….
Date

Client No. is: 000 ☐ ☐ ☐ ☐ ☐ ☐ ☐

☐ Applicant does not meet eligibility criteria. Date notified of decision: ……./……./……

Comment / Further action taken:.....

……..……..

……..……..

Referral completed Date:……/…..…/……

Referral Coordinator: ……. …….. Date:……/…..…/……
Name Signature