Referral Form

This form can be completed by a child's family member, a health professional, or a teacher/educator (with consent of the child's family). If you have any questions about this form, please call Nicky, 0493 152 471. Email the completed form to nicky@aboutplaytherapy.com.au

About My Child			
Child's full name:		DOB:	
Address:			
Gender:	□ Male □ Female □ Unspecified		
Pre-school/ Childcare/School Currently attending:		Grade (if applicable):	

My Child's Family	
Parent/Carer 1 Name:	Parent/Carer 2 Name:
Address (if different to child's):	Address (if different to child's):
Relation to child:	Relation to child:
Mobile:	Mobile:
Email:	Email:
Cultural background:	Cultural background:
Who lives at home with your child?	
Has your child or family experienced significant trauma or other events that may have had an impact on your child or family? (e.g. death in family, separation, relocation, immigration, medical problems)	

Parent/Carer Concerns

What are your main concerns for your child?

Current emotional/behavioural difficulties:

Have there been difficulties with;

Self-care
□ Toileting
□ Bathing /Showering
□ Dressing
□ Sleeping
□ Feeding

Motor skills
□ Using fingers and hands (scissor use, drawing)
□ Using larger muscles (running, jumping, balancing)
□ Using playground equipment

Communication/Learning
□ Speech (stuttering, pronouncing words)
□ Language (following instructions, using words)
□ Social skills (sharing, playing with other children)
□ Attention, concentration, organisation

Other
□ Self-harm
□ Sexualised behaviour
□ _____

Has the child been given a diagnosis?

Other People My Child Has Seen

□ None □ Occupational therapist □ Physiotherapist □ PaediatrIcian
□ Speech pathologist □ Family support services □ Psychologist □ Other

1.Name: Phone Number:

2.Name: Phone Number:

3.Name: Phone Number:

Name of GP:	Phone Number:

Funding Sources

Does your child have any of the following funding plans? □ No □ Yes (please specify)

□ NDIS number: NDIS review date:
(please provide a copy of the plan)

□ GP Chronic Management Plan (Medicare)
Referrer's Details
Referrer's Name/Organisation: Phone Number:
I have consent of the child's family/legal guardian to make this referral: □ Yes □ No □ N/A (I am child's parent legal guardian)
Additional Information:
Signature (referrer): _____ Date: _____ Signature (parent/carer):_____ Date: _____

Nicky Nilsson

Occupational Therapist/Play Therapist

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