

Integrated Therapy Services - Referral Form



Act for kids provides assessment and therapeutic interventions for children and young people who have experienced or are at risk of experiencing abuse and / or neglect. Our skilled team offers Psychology, Occupational Therapy and Speech and Language Pathology services, to help children with developmental issues and to overcome their experiences and challenges.

This form must be completed by a General Practitioner (GP), Medical Professional or Stakeholder. Please note, incomplete forms will not be accepted.

IS THIS A SUITABLE REFERRAL?		
LEGAL GUARDIAN/S consent to referral (both parents)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Child/young person's referral is a consequence of a major life stressor, change or trauma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Caregivers are willing and able to attend centre-based appointments	<input type="checkbox"/> Yes	<input type="checkbox"/> No
There are no ongoing family court proceedings	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Child/Young person being referred			
Date of referral:			
First name:		Middle name:	
Surname:		Gender:	
Date of birth:		Country of birth:	
Does the child/young person identify as Aboriginal/Torres Strait Islander?			
Language/s spoken:			
Interpreter required? If required, can the referrer fund interpreting services?			
Is the child/young person regularly attending childcare/kinder/school?			
Does the child have a formal diagnosis?			
Primary Caregiver Contact Details			
First Name:		Surname:	
Date of birth		Nationality:	
Country of birth:		Language/s spoken:	
Does the Primary Caregiver identify as Aboriginal/Torres Strait Islander?			
Address:			
Email			
Contact Number			



Additional Information

Is the child/young person eligible for funding?

DFFH (Child Protection) Intensive Family Support Family Violence Package Victims Of Crime

NDIS NDIS Plan Number: NDIS Plan Manager:

Is there a current court proceeding? Please provide details of the court order and attach copies.

Child Development Concerns
Eg.: Intellectual, learning/literacy, speech and language, social
Sensory processing and integration (sensitivity to sound, clumsy, difficulty learning new skills)
Fine motor (buttons, writing, using scissors or cutlery etc),
Gross motor, daily living activities (eating, sleeping, dressing)

Please provide details and attach any relevant reports:

Child Behaviour/Emotional Concerns
Eg: Family/siblings, parent-child relationships, sexualized behaviour, excessive fear and worry, school engagement, etc

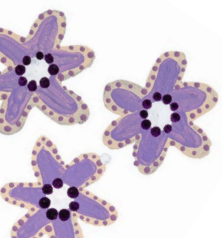
Please provide details and attach any relevant reports:



Is there a current risk concern for the child/young person linked to suicidal ideation, self-harm, or harm to others within the last 6 months?

Is there a current risk concern for the primary care giver linked to suicidal ideation, self-harm, or harm to others within the last 6 months?

Please outline details of child/young person trauma history



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Current Stakeholders/Services the child is engaged with (eg. Allied health Services, Therapists, Anglicare, NDIS, DFFH, School principal, Class teacher, Wellbeing Co-ordinator, etc)

Name	Relationship	Contact (email, phone)

Referring Person/Agency

Name:	
Agency:	
Address:	
Contact Number/s	
Email:	

Thank you for taking the time to complete our referral form for your client.

Please email to;
melbourne@actforkids.com.au

