REFERRAL FORM

Growing Early Minds is a community based, not-for-profit organisation operating across Blacktown and surrounding areas. We specialise in providing support to children and young people (0-16 years) with delay or disability, while making sure the important people in their lives have the information, resources and support needed to help them learn, develop and reach their goals.

This form can be completed by a child's family, a health professional, or a teacher/educator (with consent of the child's family). If you have any questions about this form, please call 9622 8500.

About My Child

Child's full name: _____ (*First*) _____ (*Middle*) _____ (*Surname*)

Address: _____ (*Unit/Apartment No.*) _____ (*Street Address*)

_____ (*Suburb*) _____ (*State*) _____ (*Postcode*)

Date of birth (DD/MM/YYYY): _____ Country of birth: _____

Gender: ☐ Male ☐ Female ☐ Unspecified

Is your child of Aboriginal and/or Torres Strait Islander origin? ☐ No ☐ Yes – Aboriginal ☐ Yes – Torres Strait Islander ☐ Do not wish to disclose ☐ Yes – Aboriginal and Torres Strait Islander

Is your child an Australian Citizen? (tick) ☐ Yes ☐ No Does he/she have: ☐ Permanent visa ☐ Other _____ ☐ Protected special category visa

Medicare number: _____ Medicare expiry date: _____

School/Childcare currently attending: _____ Grade (if applicable) _____

Days attending: _____

My Child's Family

Parent/Carer 1	Parent/Carer 2
Name	*Name*
Address (if different to child's)	*Address (if different to child's)*
Relation to child (e.g. mother) / *Phone (daytime)*	*Relation to child* / *Phone (daytime)*
Mobile / *Email*	*Mobile* / *Email*
Cultural background (e.g. Chinese, Aboriginal, Italian)	*Cultural background*

Languages spoken at home: _____

Do you require an interpreter? ☐ Yes ☐ No

Who lives at home with your child? _____

How long has your child lived at his/her current address? _____

Is that address likely to change within the next 12 months? ☐ No ☐ Maybe ☐ Yes (please specify) _____

Current custody arrangements/court orders (if any)? _____

My Child's Siblings

☐ No other siblings (please skip to next section)

Name | Age

Have any of these siblings been diagnosed with a developmental delay, intellectual disability or autism spectrum disorder?

☐ No ☐ Developmental delay ☐ Intellectual disability ☐ Autism spectrum disorder

Do any of these siblings currently have a National Disability Insurance Scheme plan?

☐ No ☐ Yes (please specify) _____

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)

Medical History

Has your child been diagnosed with a disability, developmental delay or impairment? If yes, please provide details:

Your child's gestation at birth (e.g. 38 weeks): _____

Were there any pregnancy or birth complications (e.g. gestational diabetes, preeclampsia, low birth weight)?

Does your child have any medical/health concerns (e.g. asthma)?

Has your child been hospitalised? If yes, when and what for?

Is your child taking any medication? If yes, please provide details:

Does your child experience reoccurring ear infections? ☐ Yes ☐ No

When were your child's last hearing and/or vision tests?

Hearing test _____ *Vision test* _____

Does your child wear glasses? ☐ No ☐ Yes - reading/short vision ☐ Yes – distance vison ☐ Yes - both

Does your child use any assistive technology/equipment (e.g. grab rails, hearing aid)?

☐ No (please skip next question) ☐ Yes (please specify) _____

Can your child perform tasks/activities effectively without their assistive technology/ equipment?

☐ Yes ☐ No – not at all ☐ No – would need prompting/supervision/assistance

Is there anyone in your child's family who has a medical condition, disability, or difficulties? If yes, please provide details:

Early Childhood

At approximately what age could your child do these actions for the first time (months/years):

Sit unsupported _____ Crawl _____ Walk _____

Say an understandable word (other than mum or dad) _____ Put two words together _____

Did your child have any difficulties learning to suck or breastfeed? (please describe) _____

Child's Interests & Strengths

What are your child's interests/preferred activities

Please list any activities your child avoids/doesn't like

What are your child's strengths? _____

Parent Concerns

Why do you want your child to be involved with Growing Early Minds? (please tick)

☐ My child's teacher/educator recommended it
☐ Not sure
☐ I am concerned about my child's development
☐ Other (please specify) _____

What are your main concerns for your child? _____

In which of the following areas of child development are you seeking support?

Communication

☐ Speech (e.g. pronouncing sounds)/ stuttering
☐ Language (e.g. following instructions, using words and sentences)
☐ Social skills

Play and Learning

☐ Attention, concentration, organisation
☐ Playing with other children (e.g. sharing)
☐ Responding to emotions appropriately

Motor Skills

☐ Using fingers and hands (e.g. using scissors, drawing etc.)
☐ Using larger muscles (e.g. running, jumping, balancing)
☐ Using playground equipment safely

Self-Care

☐ Bathing/ showering
☐ Cleaning teeth
☐ Toileting
☐ Dressing

Community Participation

☐ Participation in school/preschool/childcare
☐ Participation in community activities
☐ School readiness (If applicable) – When do you plan to send your child to school? _____

Health and Wellbeing

☐ Nutrition
☐ Sleeping
☐ Feeding and Mealtimes

Emotions/Behaviour

☐ Emotional wellbeing
☐ Separation
☐ Behaviour (please describe briefly):

Other

☐ Hearing
☐ Vision
☐ _____

Does your child have any fears? (e.g. sensitivity to noise, lights, height or different textures) _____

When did you first notice your child's difficulties/impairment/disability (months/years)? _____

How well are you coping with your child's difficulties/impairment/disability?

☐ Very well ☐ Coping okay ☐ Just coping ☐ I need support

What services are you looking for?

☐ Speech Pathology ☐ Dietetics ☐ Behaviour support ☐ Psychology ☐ Occupational Therapy ☐ Assessment

What services are you currently using?

☐ Speech Pathology ☐ Dietetics ☐ Behaviour support ☐ Psychology ☐ Occupational Therapy ☐ Assessment

☐ Other:_____ ☐ Unsure of what services required

Other People My Child Has Seen

Please tick and provide information for any of these services your child has previously been involved with or is currently seeing.
(If none apply please skip to next section.)

☐ Paediatrician ☐ Speech pathologist ☐ Specialist ☐ Occupational therapist ☐ Nutritionist/Dietitian
☐ Physiotherapist ☐ Behaviour support/Psychologist ☐ Family support service ☐ Other(s):

#1 _____ _____ _____
Profession e.g. Physiotherapist *Name* *Phone No.*

Approx. date seen _____ *Reason:* _____

#2 _____ _____ _____
Profession e.g. Physiotherapist *Name* *Phone No.*

Approx. date seen _____ *Reason:* _____

#3 _____ _____ _____
Profession e.g. Physiotherapist *Name* *Phone No.*

Approx. date seen _____ Reason: _____

Was your child *assessed* by any of the health professionals listed above? That is, were formal tests or observations conducted?
If yes, please specify the professional(s) below and attach assessment reports (if possible).

Name of GP: _____ Phone Number: _____

Funding Sources

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

☐ National Disability Insurance Scheme (please provide your child's NDIS number and a copy of the plan)

☐ GP Mental Health Treatment Plan (Medicare) ☐ GP Management Plan (Medicare)

☐ Mobility Allowance ☐ Helping Children with Autism (HCWA)/Better Start

Does your child currently access any other Commonwealth, state, or territory funding?

☐ No ☐ Yes (please specify) _____

Further Information

Referrer's contact details _____ _____
Name/Organisation *Phone No.*

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)

Is there anything else you wish to add to this referral? _____

Name of person filling out form: _____ Relation to child (e.g. mother) _____

Best time to call (days/time): _____

Contact details (if different to parent/carer): _____ _____
Phone No. *Email*

Signature: _____ Date: _____

How Did You Hear About Us and Mailing List

How did you hear about us?

Online

☐ Digital (Google search, online advertising, online database)
☐ Social Media (Facebook)
☐ Email

Referral

☐ Referral from a friend, family or colleague
☐ Referral from PECAT, Paediatrician, Physician, GP
☐ Referral from NDIS, ECEI provider or partner
☐ Referral from another provider, community centre, other
☐ Referral from a child care centre

Name of Child care centre, provider or community centre

Advertising

☐ Broadcast advertising (radio, cinema)
☐ Out-Of-Home advertising (rail, road, bus)
☐ Print advertising (newspaper, magazine, letterbox drop)

Events

☐ Event, conference or expo

Name of event, conference or expo

Other

Please specify

Is there another way we could have effectively communicated with you? A specific website or magazine?

Sign up to our mailing list

☐ I give permission (parent/carer 1) to be added to the Growing Early Minds (a service of Growing Potential Ltd.) mailing list to receive news, updates, special offers, and other marketing communication.

Please return referral forms via email at support@growingearlyminds.org.au or by mailing to:

Growing Early Minds

217-219 Blacktown Road, Blacktown NSW 2148

All information you give us will be treated as confidential and will not be shared with anyone without your permission

Permission Form

Child's Full Name _____ _____ _____
First *Middle* *Last*

Date of Birth _____ Cultural Background _____

Service / Referred by: _____

As the parent/guardian (please tick):

☐ I give permission for my child to receive services from the Growing Early Minds team

☐ I understand that consent will remain current for the period my child is involved with Growing Early Minds

☐ I understand that my child's involvement with the Growing Early Minds team may include assessments, written reports, individual/group therapy and meetings with myself and/or other relevant persons/ agencies to discuss their development and support needs.

☐ I am aware that I may be required to complete additional paperwork to allow therapist/s to obtain the most thorough, accurate information in relation to my child.

☐ I understand video, photography and voice recording may be used by the therapist/s for the purpose of conducting assessments.

☐ I understand that I can withdraw consent any given time.

I give permission to the Growing Early Minds team to exchange information about my child with other relevant persons/agencies (please tick **one**)

☐ All agencies with whom my child may be involved with; OR

☐ Only the agencies nominated below.

Local GP _____ _____
Name *Phone*

Pediatrician _____ _____
Name *Phone*

Other (please name): _____

Please note that consent to exchange information with your child's GP is required if accessing Growing Early Minds' services using a Medicare GP Management Plan.

Exceptions (if any): I do NOT give consent to the Growing Early Minds team to exchange information with the following person/s or agencies

*Please note: Growing Early Minds staff are mandatory reporters under 'The Children Legislation Amendment Act 2009', meaning they are required to liaise with other agencies if there are any concerns that a child is **at risk of harm.***

_____

_____

Parent/ Guardian's Name: _____

Parent/ Guardian's Signature: _____ Date: _____