|  |
| --- |
| **This referral form is required for clinicians and service professionals to refer a child to****the Child Development Service.**Please complete the following pages. Eligibility for an assessment will be confirmed after a detailed Intake process has occurred. If eligible, families will then be offered an appointment.**Referral Eligibility Criteria:*** Children who are likely to have a global developmental delay or intellectual disability and
* Are residents of a Northern Sydney Local Health District
* Are eligible for a Medicare card
* Have not yet started school
 |

|  |  |
| --- | --- |
| **OFFICE USE ONLY** |  |
| **Date Received** :Click here to enter text.**CDS NO**:Click here to enter text.  | *(Affix patient label here)* |
| Intake Discussion & Date: Click here to enter text.Assessment [ ]  Clinic [ ]  OT [ ]  Hold [ ]  Not for CDS [ ]   |

|  |  |
| --- | --- |
| **Referrer Details**Name:Click here to enter text.Profession:Click here to enter text.Date: Click here to enter a date. | Mailing address:Click here to enter text.Email:Click here to enter text.Phone: Click here to enter text.   |
| **Child Details**Surname: Click here to enter text. Given name:Click here to enter text.Date of birth:Click here to enter text. Sex: Male[ ]  Female[ ] Address: Click here to enter text. P/Code:Click here to enter text.  | Existing Diagnosis?: Yes [ ]  No [ ]  If yes, please specify:Click here to enter text.Interpreter Required?: Yes [ ]  No[ ]  Language: |
| **Carer Details**:Carer:Click here to enter text. Relationship to child: Click here to enter text. Phone:Click here to enter text. Email:Click here to enter text.Carer: Click here to enter text. Relationship to child: Click here to enter text.Phone: Click here to enter text. Email:Click here to enter text.Out of Home Care? Yes [ ]  No [ ]  If yes, who has Parental Responsibility? Click here to enter text. |
| **Reason(s) for referral/clinical concerns**:Global Developmental Delay [ ]  Autism Spectrum Disorder [ ]  Play/Social Interaction [ ]  | Behaviour Difficulties [ ]  Intellectual Disability [ ] Other (please specify) Click here to enter text. |
| **Current Skills:****Expressive Language** *(eg no words, single words, sentences, using gestures etc)*Click here to enter text.**Receptive Language** *(eg follows one part or complex instructions, understands gestures etc)*Click here to enter text.**Play and socialisation** *(eg pretend play, initiates interaction, shows empathy)*Click here to enter text.**Gross Motor skills**Click here to enter text.**Fine motor skills**Click here to enter text.**Behaviour concerns** *(eg tantrums, fixations, obsessions, anxiety)*Click here to enter text.**Self- help Skills** *(eg dressing, toileting, eating etc)*Click here to enter text.**Pre-academic skills** *(eg counting, colours, puzzles, memory etc)*Click here to enter text.  |
| **Background Medical History** *(including hearing or vision tests)*Click here to enter text. |
| **Relevant Psychosocial/Family History** *(eg parental separation/child protection issues/ mental health, social disadvantage)*Click here to enter text. |
| **Has the child been referred to or had any of the following?** *(please send any current reports)*Click here to enter text. |
| **Service** | **Yes/No** | **Name of Service** | (office use only)Report received  |
| Intellectual/Developmental Assessment | Yes[ ]  No [ ]  | Click here to enter text. |  |
| Occupational Therapy | Yes[ ]  No[ ]  | Click here to enter text. |  |
| Speech Pathology | Yes[ ]  No [ ]  | Click here to enter text. |  |
| Physiotherapy | Yes[ ]  No[ ]  | Click here to enter text. |  |
| Social Work/Psychology | Yes[ ]  No [ ]  | Click here to enter text. |  |
| Early Intervention Provider | Yes[ ]  No [ ]  | Click here to enter text. |  |
| Childcare/Preschool | Yes[ ]  No [ ]  | Click here to enter text. |  |
| Paediatrician | Yes[ ]  No [ ]  | Click here to enter text. |  |
| Other | Yes[ ]  No [ ]  | Click here to enter text. |  |
| NDIS funding :  | Yes[ ]  No [ ]  Applied [ ]   |  |  |
| **Is the carer aware of this referral?** Yes[ ]  No [ ] **Does the carer share your concerns?** Click here to enter text.**Additional comments or considerations before contacting the carer?**Click here to enter text.**THANK YOU FOR COMPLETING THIS FORM.** *This referral will be processed by our intake team and we will contact you with the outcome in due course.* |