AmAble
Autism & Disability Services

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Thank you for contacting AmAble. To assist us with your enquiry for Speech Pathology with Polly Hammerton could you please fill out the following form and return it to us as soon as possible.

REFERRAL FORM

Date:

Child's Name:

Date of Birth: **Age:**

Sex: ☐ M ☐ F ☐ Other

Address:

Suburb: **Postcode:**

Phone:

Email:

Referred By: **Diagnosis (if any):**

PARENT/GUARDIAN 1:

Mobile: **Email:**

PARENT/ GUARDIAN 2:

Mobile: **Email:**

CURRENT EDUCATIONAL SETTING:

School: **Year:**

Teacher/Educators Name:

Kindergarten: **Childcare:**

Other:

BIRTH HISTORY

Were there any challenges during pregnancy and/or birth? Yes ☐ **No** ☐ **(If yes, briefly describe)**

HOME ENVIRONMENT

Who lives at home with the child? (Siblings (and ages), mother, father, step-parents, grandparents, etc)

How often is English spoken at home? Always ☐ Most of the time ☐ Sometimes ☐ Never ☐

Is another language spoken, what language(s) is/are used in the home?

Any special circumstances (eg; parents divorced, joint physical custody, adoption etc)

Are there cultural or religious consideration for therapy? (holiday celebrations, prohibitions, important views values and beliefs)

OTHER PROFESSIONALS INVOLVED:

Paediatrician ☐ Psychologist ☐

Psychologist ☐ Occupational Therapist ☐

Physiotherapist ☐

PREVIOUS SPEECH PATHOLOGIST:

PREVIOUS ASSESSMENTS: No / Yes (Details)

What are your current concerns regarding your child's Speech, Language and or Social Communication?

What are the 3 main goals for child's speech therapy intervention:

1.

2.

3.

IS YOUR CHILD DIAGNOSED WITH ANY DEVELOPMENTAL OR SENSORY DISORDERS:

☐ ADHD ☐ Anxiety ☐ Autism

☐ Articulation Disorder ☐ Blind/Visually Impaired ☐ Cerebral Palsy

☐ Deaf/Hard of Hearing	☐ Degenerative Condition	☐ Dyslexia
☐ Language Disorder	☐ Learning Disorder	☐ Opposition Defiance Disorder
☐ Sensory Processing Disorder	☐ Social Communication Disorder	☐ Stuttering
☐ Other (list)		

Please provide further information for items checked above:

COMMUNICATION & SOCIAL INTERACTION

Does your child play well with other children? ☐ Yes ☐ No ☐ Sometimes ☐ Unsure

Which of the following apply to your child?

☐ Cooperative	☐ Anxious	☐ Hyperactive
☐ Frequent Tantrums	☐ Frequent self-stimulation	☐ Plays independently
☐ Easily frustrated/impulsive	☐ Inappropriate behaviour	☐ Minmal eye contact
☐ Poor understanding of danger		

Can your child clearly and appropriately communicate the following?

☐ Statements	☐ Questions	☐ Answers
☐ Wants	☐ Needs	☐ Feelings
☐ Denial/Protests	☐ Discomfort	

CANCELLATION POLICY:

As per the "Responsibilities of the Client", clients are required to provide a minimum of 48hrs notice if the client cannot make a scheduled appointment or service. If the required notice is not given, the provider may charge from the NDIS plan for participant cancellations. Each cancellation charge must not be for more than 2 hours of support and may only be applied where the participant has failed to give 48 hours notice. Where there are two scheduled appointments missed where there has been less than 48 hours notice, the Provider may elect to cancel the services agreement and recommend that the Client consult with a alternative organisation. Appointments that are canceled with the minimum 48hrs notice will have their appointment rescheduled at a time convenient to both parties.

In the event of non-attendance or cancellation of program-based services without a minimum of 48 hrs notice, the Provider may charge the full program cost to the client.

Signed: Date:

AUTHORITY TO RELEASE/OBTAIN INFORMATION

I _____ authorise AmAble to obtain and/or release

information about _____ from the contacts listed below.

I understand that this information including health/medical information is to be used in order to provide services and assistance to me/the service user /my child and family, and that this information cannot be accessed/released without authorisation.

List of people/ agencies to be contact to provide, or to be provided with information eg: medical provider, day program, school, network support staff, therapist etc.

☐ NDIA	☐ Latrobe Community Health – LAC

GP:	Support Co-ordinator:
OT:	Psychologist/ Psychiatrist:
School:	Other
I agree to be part of external NDIS quality audits (access to file/interview ☐ Yes ☐ No	
Signed:	Date:
Name:	Relationship to client (if not client):

PAYMENT DETAILS:		
☐ NDIS	☐ SELF MANAGED	
☐ FUND MANAGER	PLAN No.:	EXP:
☐ PRIVATE FUNDED	☐ BANK ACCOUNT TRANSFER	
☐ CREDIT CARD	☐ EFTPOS	

OFFICE USE ONLY
Appointment made for:
Preferred Location: