
Client details

Family name

Given names

Other names

Date of birth

Hospital of birth

Biological
Mother's name

Ethnicity

Gender

Male

Female

Other

ATSI details

Aboriginal

Torres Strait
Islander

Both

Neither

Preferred spoken
language

Legal Guardian

Relationship to
the patient

Residential address

<input type="text"/>	
<input type="text"/>	
<input type="text"/>	Postcode:

Postal address

<input type="text"/>	
<input type="text"/>	
<input type="text"/>	Postcode:

Phone
number

Email

Person completing
referralRelationship to
the patient

Phone number

Email

Medicare Card Number

IRN (Place on card)

Expiry date

CRN

Additional details

Previous diagnoses

This referral is for:

 Paediatrician only Global Developmental Delay ID Autism

If this referral is for Autism
please fill out a **Family
Referral Form**

 ADHD Neuropsychology Psychiatry FASD Other:Are there any current consent
orders or legal proceedings in
relation to the child Yes No

Details:

Patient in care of Child
Protection & Family Support? Yes No

Case worker:

Contact details

Email

Phone
number

()

Carer details

Name

Email

Phone
number

()

Patient known to Child
Development Services? Yes No

Service:

Contact details

Email

Phone
number

()

Patient known to Aboriginal Health Service? Yes No Service:

Contact details

Email Phone number ()

Development

Has the Patient had developmental assessments in the past? Yes No If yes – Service(s)

Clinician details

Were there any concerns during the pregnancy with your child? Yes No

If yes, please list

Did the child's mother use alcohol or other drugs during pregnancy? Yes No

If yes, please give details

Was your child born to full term? Yes No At how many weeks' gestation were they born?

Did your child have any health concerns at birth or before their first birthday? Yes No

If yes, please give details

Did you ever have any concerns about your child's development? Yes No

If yes, what were you concerned about?

Have you ever seen any health professionals about your child's development?

Yes No

If yes, please list

Are there things that you need to help your child with that you would expect them to be doing by themselves?

Yes No

If yes, please list

What do you think your child is good at?

--

Medical

Does your child have any ongoing health concerns?

Yes No

If yes, please list

Is your child currently taking any medication?

Yes No

If yes, please give details

Has your child needed to go to hospital?

Yes No

If yes, please give details including which hospital

How would you describe your child's sleep?

Do they have any difficulties with eating?

Yes No

If yes, please
give details

Speech Pathology

Has the Patient had Speech Therapy treatment or assessments in the past?

Yes No

If yes, please
give details

Clinician details

Current Concerns (please list)

Speech/Articulation

Language comprehension/
Understanding spoken language

Phonological Awareness/Literacy

Social skills

Stuttering (Length of time)

Voice

Feeding/Eating/Swallowing

Occupational Therapy

Has the Patient had Occupational Therapy treatment or assessments in the past?

Yes

No

If yes, service(s)

Clinician details

--

Current Concerns (please list)

Eye-hand coordination

--

Fatigues during tasks

--

Difficulty with Pencil/Scissor skills

--

Difficulty copying or
reading from a board

--

Sensory processing (e.g. difficulty
with concentration or fidgety)

--

Personal care
(e.g. toileting, dressing)

--

Feeding/Eating/Swallowing

--

Physiotherapy

Has the Patient had Physiotherapy treatment or assessments in the past?

Yes No

If yes, service(s)

Clinician details

Current Concerns (please list)

Not reaching motor milestones

Clumsiness

Moving awkwardly

Poor posture

Poor gross motor skills

Poor ball skills

Biomechanical (eg. Hip,
foot dysfunction)

Psychology

Has the Patient had Psychological treatment or assessments in the past?

Yes No

If yes, service(s)

Clinician details

Current Concerns (please list)

Behavioural concerns

Cognitive difficulties

Related history

Other

Do you have any other concerns?

Yes

No

If yes, please list

What do you hope to get out of a Patches Assessment?

--

How did you hear about Patches?

--

Patient/Legal Guardian consent

Your consent gives permission for your child (the patient) to be seen by the Patches team until your child is "discharged from the service". You may formally withdraw your consent at any time.

I give my consent for Patches to:

- Undertake assessments and therapy interventions at any site, including schools and clinics
- Obtain, release and exchange reports and relevant information (both written and verbally) with other agencies and individuals as required including:
 - › The patient's school, including school Psychologist service reports
 - › The patient's nominated GP
 - › Aboriginal Medical Services
 - › Any relevant Medical or other Child Development Services
- Make audio and/or visual recordings of my child for assessment, management and therapy purposes
- I understand that Patches is obliged to release relevant information to the Department of Child Protection pertaining to patients in care
- I understand Patches will not administer any medication to my child

Research at Patches

- As well as using the information we collect about your child for their clinical care, we also use it for research and evaluation purposes. For example, we might use your child's data for annual reports about our service, to look at ways we can improve our service, conference presentations and/or research publications.
- Whenever we present information, we do it so that identifying information is not included and you or your child cannot be identified e.g. we do not use your child's name.
- We sometimes work with researchers from outside our clinic. The research we do is approved by a Human Research Ethics Committee and tends to look at groups of people rather than just one person (e.g., what was the average age of our clients).

- While there are no direct benefits to you or your child from letting Patches use your child's information for research, this information might help us improve our understanding and treatment of various psychological and medical conditions, potentially benefiting future patients.
- It is ok if you do not want your child's information used for research purposes.
- You can change your mind at any time after signing this Consent Form.

Confidentiality

All medical records are stored securely. Only Patches staff members have access to these records, unless the law requires us to disclose it.

- Consistent with State Health policy and legal standards, all medical records are kept for a minimum of 7 years after the death of a patient and then destroyed
- Your child's information will be used as described in this form and not otherwise disclosed (unless disclosure is required by law).

If you have any questions, we can talk to you before you sign this consent form.

- I have read and understood the information provided above. Any questions that I have asked have been answered to my satisfaction.
- I understand that if I have further questions or I wish to withdraw my consent at a later date, I may contact Patches on (08) 6280 1259.
- I give my permission for Patches to enter my child's information into a database with the understanding that any information used for reports, conference presentations and/or research publications will be de-identified.
- I understand that the information I provide will be kept in the strictest confidence by Patches, unless obliged to release by law.
- I understand that, if I wish, I may ask for a copy of this Information and Consent Form.

Signatures

Name of child/client

Legal Guardian Name

Legal Guardian
Signature

Date

Send the signed and completed form to:

WA Email: diagnosis@patches.com.au
Fax: 08 6208 3202

NT Email: ntdiagnosis@patches.com.au
Fax: 08 6208 3202