**Integrated Therapy Service**
341 Payneham Road, Marden SA 5070
**Phone:** 8362 5252

**Email:** adelaide@actforkids.com.au

# REFERRAL

## Adelaide Integrated Therapy Service

*Act for Kids provides assessment and therapeutic interventions for children and young people who have experienced abuse and/or neglect, and their families. Our skilled team offers psychology, occupational therapy and speech pathology services, to help children with developmental issues and to overcome their experiences and challenges arising from their trauma. If you would like to discuss the referral and eligibility please contact us.*

*This form must be completed by a General Practitioner (GP), Medical Professional or Stakeholder.*
*Please complete all sections of this referral form electronically and send it to the above email address.*
*Your referral will be formally acknowledged in writing. Thank you.*

**DATE:** Click here to enter a date.

### DETAILS OF CHILD/YOUNG PERSON BEING REFERRED

| | | | | | |
|---|---|---|---|---|---|
| Client Name: | | | Client Phone Contact (if applicable): | | |
| Address: | | | Suburb: | | |
| D.O.B: | | Gender/Gender Identity: | | | |
| Cultural Background: | | Country of Birth | | Language at home | |

| School/centre | Year level | Contact person | Phone contact |
|---|---|---|---|
| | | | |
| Living Situation: | | | |
| ☐ Home ☐ Residential Care ☐ Out of Home Care ☐ Kinship Care ☐ Other – please provide details: | | | |

### REFERRAL INFORMATION

| | | | |
|---|---|---|---|
| 1. | Is the child aged 17 years or under | ☐Yes | ☐ No |
| 2. | Is the young person living in a stable home environment and is not in crisis (i.e not currently living with alleged offender)? | ☐Yes | ☐ No |
| 3. | Has the child experienced physical, emotional, sexual harm or neglect, or is at risk of such harm? | ☐Yes | ☐ No |
| 4. | Has this referral been discussed with the legal guardian, and do they consent to this referral? | ☐Yes | ☐ No |
| 5. | The young person's caregiver / guardian is willing to participate in therapy intervention. | ☐Yes | ☐ No |
| 6. | Is the young person subject of a **current** court proceeding? | ☐Yes | ☐ No |
| 7. | Is the child receiving NDIS funding for Therapeutic Supports? | ☐Yes | ☐ No |
| 8. | Is the child under Guardianship of the Chief Executive/Child Protection Order? *If YES, referrals for Psychology must be submitted to the *DCP Private Providers of Psychological Services Panel*. For further information about this process please contact us on 8362 5252. | ☐Yes* | ☐ No |

## PRIMARY CAREGIVER OF CHILD/ YOUNG PERSON

| | | | |
|---|---|---|---|
| Name: | | Relationship to child: | |
| Phone contact: | | Date of Birth: | |
| Email address: | | Country of Birth: | |
| Address: | | Suburb: | |
| Is the parent/carer willing to bring their child to the centre and participate in the therapy process? ☐Yes ☐No | | | |
| Who has legal parental responsibility (PR) for this child? | | | |

**Please list other people living in the same household as the young person:**

| Name | Relationship to child/young person being referred | Age (years) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Other significant family members living outside of the child/young person's home:**

| Name | Relationship to child/young person being referred | Age (years) |
|---|---|---|
| | | |
| | | |
| | | |

## REFERRER SOURCE (AGENCY / ORGANISATION)

| | | | |
|---|---|---|---|
| Agency: | | Referral person: | |
| Position: | | Line supervisor: | |
| Email address: | | Phone contact: | |
| Address: | | Suburb: | |
| Preferred mode of contact: ☐email ☐phone | | | |

## OTHER SERVICE INVOLVEMENT

| | | | | | |
|---|---|---|---|---|---|
| Dept for Child Protection | ☐ | NGO services | ☐ | Family Court | ☐ |
| Allied Health Services | ☐ | School Guidance Officer | ☐ | Counsellor / Other | ☐ |
| Medical Practitioner | ☐ | Details: | | | |

## SUGGESTED INTERVENTION FOCUS

***Please indicate the desired focus of intervention (you can tick more than one box)***

☐ Psychology Counselling
☐ Occupational Therapy
☐ Speech and Language Therapy
☐ Counselling

## REASON FOR REFERRAL *(Please be mindful of the privacy of others when completing this field)*

| History of abuse or neglect with regards to the child/young person | |
|---|---|
| Sexual abuse<br>☐Yes ☐ No | If yes, provide details: |
| Physical abuse<br>☐Yes ☐ No | If yes, provide details: |
| Emotional abuse<br>☐Yes ☐ No | If yes, provide details: |
| Neglect<br>☐Yes ☐ No | If yes, provide details: |
| Multiple changes in Caregiver<br>☐Yes ☐ No | If yes, provide details: |
| Previous or current interventions<br>☐Yes ☐ No | If yes, provide details: |

| Presenting current risk concerns: | |
|---|---|
| Current suicidal thoughts<br>☐Yes ☐ No | If yes, provide details: |
| Current self-harming behaviours<br>☐Yes ☐ No | If yes, provide details: |
| Aggressive behaviour<br>☐Yes ☐ No | If yes, provide details: |

| Child behaviour/emotional issues: | |
|---|---|
| Family/sibling issues<br>☐Yes ☐ No | If yes, provide details: |
| Parent-child relationship issues<br>☐Yes ☐ No | If yes, provide details: |
| Sexualised behaviour<br>☐Yes ☐ No | If yes, provide details: |

| Child behaviour/emotional issues (continued): | |
|---|---|
| Emotional adjustment<br>☐Yes ☐ No | If yes, provide details: |
| General health issues<br>☐Yes ☐ No | If yes, provide details: |
| Other concerns<br>☐Yes ☐ No | If yes, provide details: |

| Developmental concerns: | |
|---|---|
| Intellectual difficulties<br>☐Yes ☐ No | If yes, provide details: |
| Learning/literacy difficulties<br>☐Yes ☐ No | If yes, provide details: |
| Speech/language difficulties<br>☐Yes ☐ No | If yes, provide details: |
| Activities of daily living<br>☐Yes ☐ No | If yes, provide details: |
| Sensory processing difficulties<br>☐Yes ☐ No | If yes, provide details: |
| Gross motor difficulties<br>☐Yes ☒ No | If yes, provide details: |
| Fine motor difficulties<br>☐Yes ☐ No | If yes, provide details: |
| Social difficulties<br>☐Yes ☐ No | If yes, provide details: |
| Hearing/vision previously assessed?<br>☐Yes ☐ No | If yes, provide details: |

**SUPPORTING DOCUMENTS (OPTIONAL)**

- ☐ Consent forms
- ☐ Genogram ***(please provide if known)***
- ☐ Current case plan
- ☐ Child Protection history
- ☐ Permission to exchange information form
- ☐ Assessments
- ☐ Court documents
- ☐ Other:

**THANK YOU FOR YOUR REFERRAL**

**Please email your referral to: adelaide@actforkids.com.au**