Integrated Therapy Service – Referral Form

Integrated Therapy Service – Sunshine Coast Level 1, 102- 104 Howard Street, Nambour QLD 4560
Email: SunshineCoastITS@actforkids.com.au **Phone:** 07 5451 8250

CONSENT

All referrals must come with the knowledge and consent of the client and client's LEGAL GUARDIAN. The referring person/agency confirms that they have discussed the referral with the child/young person, their guardian and have obtained their consent to submit this referral.

Consent obtained from (name)		Date consent obtained

DETAILS OF CHILD/YOUNG PERSON BEING REFERRED

Date of referral			
First name		Middle name	
Surname		Gender	
Date of birth		Country of birth	
Language/s spoken		Interpreter required	
Identifies as		Cultural/Spiritual Practice?	
Address			
Is the child/young person attending childcare/school? Provide name			
Does the child/young person have any diagnosis?			
Current living situation?			

REASON FOR REFERRAL

Current concerns? What prompted referral at this time (description of trauma on page 3)

In the parent's words, are their goals and hopes for therapy? *e.g., reduce child anxiety, improve relationships, understand child's behaviours, parenting skills, less conflict in the home, improve school attendance*

In the young person's words, what are their goals and hopes for therapy? *e.g., reduce worries, overcome thoughts/feelings about my past, feel safer, have better relationships, feel like I belong, achieve at school, be able, sleep better.*

REFERRAL INFORMATION

Child/young person's referral is a consequence of a major life stressor, change or trauma?	☐Yes	☐No
Caregivers are willing and able to attend and transport to centre-based appointments?	☐Yes	☐No
Is the child/young person aware of this referral and Act for Kids and willing to participate?	☐Yes	☐No

Is the child/young person subject of a current court proceeding or is the child/young person named on an Intervention Order, Domestic Violence Order or other? If yes, specify below.

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ABOUT CHILD AND THEIR FAMILY
Child/young person's strengths and skills: *e.g. personal characteristics/things that they are good at*
Interests/Activities/Hobbies that child enjoys: *e.g. favourite toys/games, gaming, sport, craft, drawing, YouTube/tv*
Strengths of the family. Interests and activities they enjoy:

PRIMARY CAREGIVER CONTACT DETAILS			
First Name		Surname	
Date of birth		Relationship to child/young person	
Gender		Country of birth	
Language/s spoken		Interpreter required	
Identifies as		Cultural/Spiritual Practice	
Address			
Contact Number		Email:	
Is the carer the Legal Guardian?	☐ Yes ☐ No - ***If you selected no please enter the Legan Guardian's details below***		

LEGAL GUARDIAN CONTACT DETAILS IF DIFFERENT FROM CAREGIVER ABOVE			
First Name		Surname	
Date of birth		Relationship to child/young person	
Gender		Country of birth	
Language/s spoken		Interpreter required	
Identifies as		Cultural/Spiritual Practice	
Address			
Contact Number		Email	

FAMILY/PEOPLE IN CHILD/YOUNG PERSON'S LIFE
Name, relationship to child/young person and age

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TRAUMA HISTORY (Focus on this child's history and please be mindful of privacy of others when completing this field)
Please outline any details of child/young person's trauma history, *e.g., single/multiple/complex trauma, disruption to attachment with family, domestic violence, abuse, intergenerational trauma, please indicate if they have experienced living in out of home care.*

CHILD DEVELOPMENT CONCERNS (Please check all that apply and describe)	
☐ **Delayed early developmental milestones?**	☐ **Daily living activities?** (Eating/sleeping/dressing/bathing)
☐ **Sensory?** (Sensitivity to sound, clumsy, constantly moving, difficulty learning new skills)	☐ **Developmental regression?** (bed-wetting/soiling, baby talk/babbling, decreased vocabulary)
☐ **Gross motor?** (Climbing, jumping, balancing)	☐ **Hearing/Vision previously assessed?**
☐ **Fine motor?** (Drawing, writing, buttons, zips scissors, building with Lego)	☐ **Speech/Language/Literacy/Learning difficulties**

Is there a current risk concern for the child/young person linked to suicidal ideation, self-harm, or harm to others within the last 6 months?
Is there a current risk concern for the primary carer linked to suicidal ideation, self-harm, or harm to others within the last 6 months?

Current Stakeholders engaged *eg. Case Managers, NDIS, DFFH, School Principal, Class teacher, Wellbeing Co-Ordinator, Allied Health Professionals etc*
Please include name(s), role and contact (email, phone)

REFERRING AGENCY/PERSON			
Name:		Agency:	
Address:		Contact Number/s	
		Email:	

Please ensure you attach copies of relevant documents/reports and email to: SunshineCoastITS@actforkids.com.au
Thank you for taking the time to complete our referral form.

Act for kids