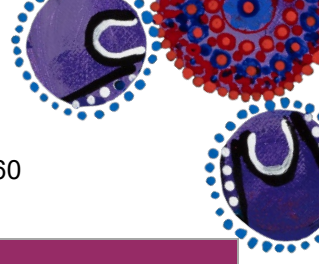


Integrated Therapy Service – Referral Form



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.

Integrated Therapy Service – Referral Form

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

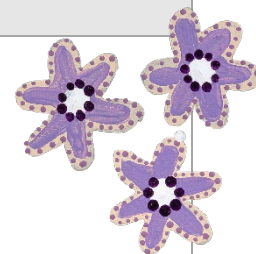
First Name		Surname	
Date of birth		Relationship to child/young person	
Gender		Country of birth	
Language/s spoken		Interpreter required	
Identifies as		Cultural/Spiritual Practice	
Address			
Contact Number		Email:	
Is the carer the Legal Guardian?	<input type="checkbox"/> Yes <input type="checkbox"/> No - <i>If you selected no please enter the Legan Guardian's details below</i>		

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



Integrated Therapy Service – Referral Form

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)

<input type="checkbox"/> Delayed early developmental milestones?	<input type="checkbox"/> Daily living activities? (Eating/sleeping/dressing/bathing)
<input type="checkbox"/> Sensory? (Sensitivity to sound, clumsy, constantly moving, difficulty learning new skills)	<input type="checkbox"/> Developmental regression? (bed-wetting/soiling, baby talk/babbling, decreased vocabulary)
<input type="checkbox"/> Gross motor? (Climbing, jumping, balancing)	<input type="checkbox"/> Hearing/Vision previously assessed?
<input type="checkbox"/> Fine motor? (Drawing, writing, buttons, zips scissors, building with Lego)	<input type="checkbox"/> 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.