shannon.health@outlook.com
ABN: 96108467642
Phone: 0437112218

Shannon Health

Referral DATE:	
Client Name (including Guardian if applicable)	
DOB	School Year:
Phone and Email Contact:	
Postal Address	
Classroom Teacher Name/Contact:	
Presenting Issues/Referral Needs:	
Specific Assessments required (eg. Cognitive, Sensory, Autism Diagnostic, Learning Disorders).	

Referring Medical Practitioner Details

Practitioners Name:
Practitioner Address:
Phone:
Email:

Type of Referral – Please tick one

- ☐ MHCP – Mental Health Care Plan. Please attach Plan
- ☐ Private Health Insurance Cover
- ☐ Self Funded- (non medicare/private health)
- ☐ Workcover – Claim Number Insuring Agent Insurer Case Manager Name:
- ☐ NDIS Therapeutic Support– please complete further details below
- ☐ Other please specify

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NDIS Referrals
NDIS Plan Number
Carer Contact where relevant:
Residential Address (or as above):
NDIS Plan Start Date:
NDIS Plan End Date:
NDIS Plan Type: ☐ Self Managed ☐ NDIS Managed
☐ NDIS Managed Plan Managed – Agency Name:
Referrer:
Role of Referrer:
Referrer Contact:
Referrer Email:
Reason for Referral/Client Needs: (additional details)

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Background information

Please complete the below sections to the best of your knowledge.

Family Details

Pregnancy
Normal Delivery: Complicated Delivery:
Number an age of any siblings:
Family Medical History: (medical/mental health)

Child Details

Medical History

Past/Present Medical Conditions	Age of Onset	Treatment received/ Current status

Medications

Medication Name	Dosage	Purpose

Previous Diagnosis

Other Diagnosis	Given By/Health Professional	Intervention Implemented

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Interventions Received

Other Health Professionals	Commenced seeing	Current Intervention Details

Development Milestones

Gross Motor

Skill	Age first occurred or NA
Rolled Over front to back and back to front	
Sitting unaided	
Reached deliberately for person or object	
Crawled forward	
First Steps (2 – 3 steps taken)	
Walking smoothly	
Rode bike with training wheels	
Able to kick a ball deliberately	
Rode bike no training wheels	

Fine Motor

Skill	Age first occurred or NA
Pick up smaller items (bead, sultanas)	
Brings Spoon to Mouth	
Builds tower with 3-4 blocks	
Able to feed self unaided	
Turns door knobs	
Uses one hand consistently in most activities (name hand)	
Cuts on a line	
Drew with pencil/scribble	
Draw Shapes	
Draw object can recognise	
Wrote Name	
Ties shoelaces	

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Social Skills and Language development

Skill	Age first occurred or NA
Made eye contact for up to 2 seconds +	
First smile	
Smile at others	
Laughs in respond to play	
Pays attention to own name	
Plays turn taking games (eg. peekaboo)	
Age become weary of strangers	
Age engages in imaginary play	
Points to express want they want	
Responds to feeling of others /facial expressions of others	
Began cooing – making noises	
Began babbling eg. dadada, bababa	
First words	
Understand word commands (arms up)	
Spoke 2 word phrases (reach me)	
Take turns in conversation	
Respond to questions asked	
Spoke in sentences up to 3 words or more	
Imitates actions of adults	

Consent Form and Information

Background information

Information Collection:

As part of providing a psychological services and/or occupational therapy services, personal information will be requested. This information informs the assessment and treatment being provided. Your informed consent will be obtained before any treatment procedure is initiated, and you may withdraw from treatment at any time without prejudice. You are not obligated to provide any personal information requested; however, withholding information may prevent the therapist from providing you with the services you require. The information retained includes personal contact details, service and billing history and clinical notes and correspondence. However, the Practice limits and restricts the recording of information

(including all clinical notes and records) to the bare minimum required to facilitate the provision of the service. We would like to emphasise that your privacy and the information that you provide is protected at all times. All of our psychologists and occupational therapists are registered with the Australian Health Practitioner Regulation Agency (AHPRA) and it is a requirement that all psychologists and occupational therapists follow strict guidelines for professional conduct that is in line with AHPRA and the Australian Psychological Society (APS) Code of Ethics, and Occupational Therapy Australia code of ethics.

Privacy and Security of Client Information

Client files are held in secure physical and electronic storage and are only accessible by your psychologist and practice management. General service, billing and contact information may be accessed by practice management for any reasonable and lawful purpose (e.g. appointment reminders, financial reporting, customer service, etc.) but will never be shared or disclosed to a third party unless required by law.

Confidentiality:

Therapy services are bound by the legal requirements of the National Privacy Principles as set out in the Privacy Amendment (Private Sector) Act 2000. Upon request, you can obtain a copy of these principles, which describe your rights and how your information should be handled. If you have any concerns regarding the collection or storage of your personal information please inform the psychologist

All personal information gathered by the psychologist during the provision of therapy services will remain confidential and secure except when:

1. It is subpoenaed by a court;
2. Failure to disclose the information would place you or another person at risk;
3. Your prior approval has been obtained to:
    a. Provide a written report to another professional or agency (e.g. teacher);
    b. Discuss the material with another person (e.g. a parent or employer)
4. If you are referred by a GP under a MHTP or CDM you are consenting to the exchange of written/ verbal correspondence regarding your treatment and progress.

Consent to Disclose Information:

Please read this section carefully, and sign below.

Shannon Health is authorised to collect and disclose my personal information, for the purposes of assessment and / or therapy/intervention for which I (my child) have been referred from the following people / organisations:

Shannon Health

☐ Yes	Treating Therapist (e.g. Physiotherapists, speech pathologist, occupational therapist and/or psychologist)
☐ Yes	Treating Medical providers including specialist (e.g. doctor, paediatricians, psychiatrists, specialist doctors)
☐ Yes	NDIS support coordinators, plan managers or LAC
☐ Yes	Aids and Equipment suppliers/service providers
☐ Yes	School and other relevant education organisations

Parent/Client Agreement and Consent

Please print your name and sign below to indicate that you have understood and agree to these terms of service.

I, (PRINT FULL NAME) _____, understand and agree to the above terms of service, policies, fees and procedures in full and acknowledge that my agreement is a fair and reasonable condition of the provision of services for myself and/or my child.

Signed: _____ Date: ____ / ____ / _____

On behalf of: (Print names of any children who are to receive services in BLOCK CAPITALS)

_____

Please return referral via email to shannon.health@outlook.com If you require any additional information or questions please contact 0437112218