# REFERRAL FORM

**CONFIDENTIAL**

## PARTICIPANT INFORMATION

| | | | |
|---|---|---|---|
| **Name of participant:** | | | |
| **Participant Representative:** | | | |
| **Date of birth:** | **Age:** | | |
| **Address:** | | | |
| **Phone number:** | | | |
| **Email:** | | | |
| **Diagnosis:** | | | |

## GOALS AND ABILITIES

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|---|---|
| What **goals** would you like to focus on in music therapy? What do you hope to achieve through music therapy? | |
| Do you participate in **any other allied health or health services?** *(i.e. physiotherapy, occupational therapy, psychiatrist)*<br><br>How often do they attend these services? | |

| | |
|---|---|
| Describe any abilities or challenges that the participant experiences<br><br>(physical abilities/disabilities, communication skill, psychological/emotional, cognitive/comprehensive, or behaviours of risk (seizures/aggression/allergies) | |

## MUSICAL BACKGROUND

| | |
|---|---|
| What musical instruments do you have access to in the home environment? | |
| What kind of music does the participant engage most with? (nursery rhymes, pop music, classical music, rock music) | |
| What musical interests or skills have you observed? (vocal, movement, instruments, social) | |
| Is there anything else that you feel is important to know about the participant? | |

## AVAILABILITY

| | |
|---|---|
| What is your current availability? | |
| The participant will be accessing this service through (private, NDIS self or plan managed?) | NDIS Plan-Managed |
| How did you find out about our services? (internet, OT, Speech, Doctor, word of mouth) | |

**Please read the following information and tick the boxes once approved.**

## Terms and Conditions:

1. **Attendance** - if the Initial Consultation is successful, participants are expected to attend sessions on a weekly basis
**2. Supervision** - if a representative/parent or support practitioner is required, they must remain on the premises while the provider is on-site.
**3. Payment -** Session fees are payable on a weekly basis via direct debit and must be received within 14 days of the invoice date.
**4. Cancellations** - notice of cancellation must be provided by the participant or their representative no later than **3:00pm on the day prior to the scheduled service**. Cancellations made after this time will incur a cancellation fee of **100% of the session fee.**

☐ **I have read and understood the terms and conditions and any questions I have asked, have been answered to my satisfaction.**

You agreed to be bound by our terms and conditions as stated above when you ticked the above statement.

## Consent:

☐ **I confirm I have consent from the participant or their representative to share this information for the purpose of this referral.**

## Privacy Statement:

All information provided in this form will be kept confidential and used solely for the purpose of processing this referral and delivering services through Serenity Music Therapy. Your information will not be shared with third parties without consent.

## Thank You

Thank you for your referral. I appreciate your time and will contact you as soon as possible to discuss the next steps.

SERENITY MUSIC THERAPY

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