0402 167 055
WWW.SERENITYMUSICTHERAPY.COM.AU
LUCY.SERENITYMUSICTHERAPY@GMAIL.COM

REFERRAL FORM

CONFIDENTIAL

PARTICIPANT INFORMATION

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

GOALS AND ABILITIES

What goals would you like to focus on in music therapy? What do you hope to achieve through music therapy?	

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Do you participate in any other allied health or health services? (OT, physio, psychiatrist) How often do they attend these services?	
Describe any **sensory** abilities/difficulties (vision, hearing, touch)	
Does the participant exhibit any additional behaviours of importance or **risk**? (seizures, anxiousness, aggression - biting, hitting, risk considerations to others)	
Describe any **physical** abilities/difficulties (ability to walk, wheelchair user)	
Describe any **communicative** abilities/difficulties (pre-verbal, verbal, balling, singing)	
Describe any **psychological/emotional** abilities/difficulties (anxiety, confidence, psychotic symptoms, fatigue)	
Describe any **cognitive/comprehensive** abilities/difficulties (receptive/expressive language skills)	

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)	
How often does the participant use music in your household and for what use?	
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?)	
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. Participants are expected to attend on a weekly basis
2. A parent/carer must remain on the premises whilst the provider is on-site
3. Fees are payable on a weekly basis by direct debit within 7 days of the invoice date
4. Cancellation policy: Notice of cancellation must be provided by the participant/participant's representative by 3pm on the day before the scheduled service. Cancellations made after 3 pm on the day before the service will incur a cancellation fee of 100% of the agreed price for the cancelled appointment.

☐ **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 guardian 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.

LUCY MORGAN
REGISTERED MUSIC THERAPIST
B. MUSIC (PERFORMANCE) | MASTER OF MUSIC THERAPY
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