

REFERRAL FORM - INITIAL

This form is to be used where the child/young person is not an existing client of CanDo4Kids

Child / Young Adult

Name: **Date of Birth:**...../...../.....

Address:..... **M** **F**

..... **School:**

.....**PC** **Year:** **DECS** **Catholic** **Ind.**

Nature of sensory impairment **Vision** **Hearing** **(Deafblind) Dual sensory**

Diagnosis:

Are corrective lenses prescribed? **Yes** - Glasses Contact lenses **No**

VA: Uncorrected R ; L ; BEO : Corrected R ; L ; BEO :

Are hearing aid/s prescribed? Hearing Aid Cochlear Implant

HI: Right - Mild Mod Sev Prof **Left** - Mild Mod Sev Prof

Is the primary disability sensory? **Yes** **No**

If No, what is the primary disability of the child / young adult:

- | | |
|--|--|
| <input type="checkbox"/> Physical | <input type="checkbox"/> Intellectual disability |
| <input type="checkbox"/> Development Delay (0-5yrs. only) | <input type="checkbox"/> Speech impairment |
| <input type="checkbox"/> Acquired Brain Injury | <input type="checkbox"/> Neurological (eg. Epilepsy) |
| <input type="checkbox"/> Autism, including Asperger's syndrome | |

Other Organisation involved for primary disability	Contact Person / Contact Number
.....
.....
.....

Parent/Caregiver	Parent/Caregiver
Name(s):
Relationship:
Address:
..... PC PC
Phone Number: (H).....	(H).....
(W).....	(W).....
(Mob).....	(Mob).....
Email:

Name of person referring: Date of referral:

Organisation:

Contact Phone Number:

Contact Address:

.....

Relevant Coordinating Service Early Intervention BVI Family Support Services BVI

Early Intervention DHI Family Support Services DHI

Specific Service Requested

Assistive Technology Occupational Therapy Youth Work

Speech Pathology / AVT Auditory Processing Clinic Mentor Program

Reason for referral: Please describe the child's / student's needs

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I consent to this referral and to CanDo4Kids Community Services staff contacting those named on the form to share further information regarding vision / hearing and support needs.

Parent' / Caregiver's Name:

Signature:Date:.....

Please note: Before a service is offered CanDo4Kids will follow a process to determine eligibility, appropriateness and whether resources are available to provide the service requested. You will be informed of the outcome when the referral process has been completed.

OFFICE USE ONLY

Referral received by:..... Passed to Referral received Date:/...../.....

Initial Appointment date:/...../.....

Assessment completed:.....

Applicant meets client eligibility criteria. Service Provider is:

Client No. is: 000

Applicant does not meet eligibility criteria. Date notified of decision:/...../.....

Comment / Further action taken:

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Community Services Manager: Date:.....

Or representative Name Signature