# Request for Support – Therapy Team

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# Child Development Service

**Whakapiki Hauora o te Tamaiti me te Whānau**

**To improve, promote and support the health of the child and** **whānau**

**Please tick services required:**

Occupational Therapy  Physiotherapy  Speech Language Therapy  Dietitian  Social Work

Housing  Equipment Wheelchair / Seating  Kaitautoko /Whānau Support

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| CHILD AND WHĀNAU/FAMILY INFORMATION | | | | |
| Child’s name: | | NHI: | DOB: | Ethnicity: |
| Address/s: | | | | |
| Phone numbers: Home:       Mobile: | | | | |
| Email address: | | | | |
| Parent/Caregiver’s names: | | | | |
| Is the family/whānau/caregiver aware of the referral?  Yes  No Reason for no: | | | | |
| Contact referrer first?  Yes  No | | | | |
| Will an interpreter be required?  Yes  No Language spoken at home: | | | | |
| concerns and priorities | | | | |
| Forms with insufficient information will be returned | | | | |
| **What are the concerns and/or priorities of the whānau/family/ caregiver?** |  | | | |
| **What specifically are the whānau/ family/caregivers requesting support with?** |  | | | |
| diagnosis and clinical information | | | | |
| Diagnosis/Disability |  | | | |
| Clinical information |  | | | |
|  | *Please attach any reports or further information that will assist with triage*. | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ADDITIONAL INFORMATION | | | | | |
| GP | |  | | | |
| Lifelinks | | Yes  No  Unsure | | | |
| Other professionals | | *e.g. Paediatrician, Orthopaedic consultant, Orthopaedic coordinator, Neurologist, Children’s Outreach Nurse, Palliative Care CNS, Child Development CNS, Child Development Coordinator, ASD coordinator, Explore behaviour, Plunket, Early Start, Right Service Right Time, Ministry of Education* | | | |
| Preschool/School | |  | | ORS funded:  Yes  No  Unsure  High Health funded:  Yes  No  Unsure | |
| Ministry of Education professionals | | *e.g. Early Intervention Teacher, SLT, Psychologist,* *Kaitakawaenga, PT, Occ Th,* | | | |
| Referrals made  to others | |  | | | |
| REFERRED BY | | | | | |
| Name: | | | Title: | | Date: |
| Contacts | Phone: | | | Email: | |