Ripples Allied Health Consultancy

Shop 4B, 44-52 Princes Hwy, Dapto NSW 2530
Mail: PO Box 227 Dapto 2530

loanpham.ripples@gmail.com
www.ripplesahc.com.au

M: 0479 055 023
ABN: 55 816 911 851

CHILD/YOUNG PERSON REFERRAL FORM

Child/Young Person's details

Name: _____ D.O.B.: _____

Address: _____ Email: _____

_____ Mobile: _____

Client's Medicare #: _____ Ref #: _____ Expiry: _____

Parent Medicare #: _____ Ref #: _____ Expiry: _____

VC Approval #: _____ Nationality: _____

Country of Birth: _____ NDIS Ref: _____

Physical Disability: _____ Plan Manager (PM): _____

_____ PM Email: _____

Aboriginal or Torres Strait Islander ☐ Aboriginal ☐ T.S.I ☐ Both ☐ Neither ☐ Unknown

MHCP Referral Details (Please Attach Mental Health Care Plan):

G.P. Name: _____ Plan Date: _____

Address: _____ Phone: _____

Provider #: _____ Fax: _____

Parents/Carer: **Parent 1: ☐ N.Father ☐ Foster.F ☐ Step.F** **Parent 2: : ☐ N.Mother ☐ Foster.M ☐ Step.M**

Name: _____ _____

Phone: _____ _____

Address: _____ _____

_____ _____

Email: _____ _____

Sibling's Name: _____ D.O.B.: _____ M ☐ F ☐

Sibling's Name: _____ D.O.B.: _____ M ☐ F ☐

Sibling's Name: _____ D.O.B.: _____ M ☐ F ☐

Sibling's Name: _____ D.O.B.: _____ M ☐ F ☐

Referrer/ Case manager: _____ Phone: _____

Organisation: _____ Email: _____

Address: _____ Mobile: _____

_____ Fax: _____

Court Orders: **Is there a current court order in place? If so please provide a copy of this**

Ripples Allied Health Consultancy
Shop 4B, 44-52 Princes Hwy, Dapto NSW 2530
Mail: PO Box 227 Dapto 2530
loanpham.ripples@gmail.com
www.ripplesahc.com.au
M: 0479 055 023
ABN: 55 816 911 851

Past Psychologists Involved

Name/ Dates _____ Phone: _____

Name/ Dates _____ Phone: _____

Other Specialists Involved

Name: _____ Phone: _____

Name: _____ Phone: _____

Reasons for Referral

Please indicate below which of the following are concerns about this child/young person. Do not mark items that are not of concern. Indicate severity of concern as follows: ***XXX*** *Most severe/important,* ***XX*** *Less severe or* ***X*** *Problems, but not severe.*

Severity

☐ a. Toileting: Bedwetting, soiling, smearing, regressed to diapers, constipation _____

☐ b. Eating: Refuses to eat, compulsion to eat, picky eater, vomiting/purging, obesity _____

☐ c. Sleeping: Difficulties falling asleep, night waking, apnea, sleep-walking, terrors. _____

☐ d. Attention: Inattention, distractibility, can't concentrate. _____

☐ e. Aggression: Fighting/bullying, setting fires, hurting animals, destroying property. _____

☐ f. Self-Destruction: Cuts, hits, kicks, burns, bangs head, risk taking, suicidal. _____

☐ g. Social Skills: No friends, prefers younger/older peers, loses friends quickly. _____

☐ h. Depression: Withdrawal, low energy, hopeless, sad, helpless, suicidality (current? ☐Y ☐ N) _____

☐ i. Anxiety: clinginess, fears, shy, easily startled, panicky, hyperventilates. _____

☐ j. Activity Level: Over-active, hyperactive, out of control, inactive, passive. _____

☐ k. Memory: Disorientated, Seeming lost, forgetful, memory impairments, odd statements. _____

☐ l. Movement Problems: Twitches, tics, paralysis, seizures, weakness, compulsions. _____

☐ m. School: Falling grades, suspended, expelled, refuses to attend, bullying. _____

☐ n. Sexual: Preoccupation, intrusive ideas, exposing self, touching others _____

☐ o. Medical Problem: Chronic illness, terminal illness, medication non-compliance _____

☐ p. Separation/loss: Death, divorce, relocation. _____

☐ q. Oppositional/defiant: Disrespectful, defies authority, disobedient. _____

☐ r. Delinquent: Theft, assault, police involvement, court order. _____

☐ s. Drugs and Alcohol: Experimentation, abuse, addiction, peer pressure, trafficking. _____

☐ t. Behavioural issues: disability support required, challenging behaviours impacting on outcomes _____

☐ u. Trauma: see below _____

☐ v. Developmental: cognitive delay, neurological condition, Autism Spectrum Disorder etc _____

Ripples Allied Health Consultancy

Shop 4B, 44-52 Princes Hwy, Dapto NSW 2530
Mail: PO Box 227 Dapto 2530

loanpham.ripples@gmail.com
www.ripplesahc.com.au

M: 0479 055 023
ABN: 55 816 911 851

Trauma History: *Please indicate if you have a history of trauma and the age when this trauma occurred*

Childhood sexual: _____ Ward of state: _____

Adult Sexual Abuse: _____ Neglect: _____

Physical Abuse: _____ Domestic Violence: _____

Natural Disasters: _____ Bullying: _____

Victim of relative Homicide: _____ Cyber safety: _____

War Crimes: _____ Medical complications: _____

Parent was frightening: _____ Parent frightened: _____

Health: *Please indicate here any current/previous physical conditions/illnesses or psychological diagnosis:*

Diagnosis: _____ Diagnosed by: _____

Diagnosis: _____ Diagnosed by: _____

Diagnosis: _____ Diagnosed by: _____

Diagnosis: _____ Diagnosed by: _____

Prescribed Medication: *Please indicate here medications the child is currently taking:*

Medication	Dosage	Frequency	Prescribed by Whom?

Family History: *Please indicate here any known family history of physical (example: epilepsy, diabetes) or psychiatric (example: Manic-depressive illness) disease:*

Relation: _____ Illness/Condition _____

Relation: _____ Illness/Condition _____

Relation: _____ Illness/Condition _____

Relation: Illness/Condition

Extra-Curricular Activities: *Please list any activities that your child engages in that may conflict with scheduled appointments, and which can also provide us an understanding of your child's strengths*

Activity 1: _____ Days/Times _____

Activity 2: _____ Days/Times _____

Activity 3: _____ Days/Times _____

Ripples Allied Health Consultancy

Shop 4B, 44-52 Princes Hwy, Dapto NSW 2530
Mail: PO Box 227 Dapto 2530

loanpham.ripples@gmail.com
www.ripplesahc.com.au

M: 0479 055 023
ABN: 55 816 911 851

Preschool Details:

School: _____ Grade: _____

Address: _____ Phone: _____

_____ Email: _____

Teacher: _____ Fax: _____

Primary School Details:

School: _____ Grade: _____

Address: _____ Phone: _____

_____ Email: _____

Teacher: _____ Fax: _____

_____ _____

High School Details:

School: _____ Grade: _____

Address: _____ Phone: _____

_____ Email: _____

Teacher: _____ Fax: _____

HAS THE CHILD…? (*Please provide details on any YES responses, and attach reports)*

Failed or Repeated Grade	☐ Yes ☐ No	Had prolonged absences from school?	☐ Yes ☐ No
Had Psychological Testing	☐ Yes ☐ No	Been suspended or expelled before?	☐ Yes ☐ No
Had Speech Testing	☐ Yes ☐ No	Had Audiological testing?	☐ Yes ☐ No

Other Information (For Example, strengths, recent incidences etc)

Thank you for the time you have taken to complete this form. It is much appreciated.