

Options

ABN: 48 090 446 638

Communication Therapy and Training Centre

Postal Address: P.O. Box 568, Kallangur, 4503, Queensland Australia

Tel/Fax: (07) 3285 5522 Mobile: 0410 448 523

Email: optionsctc@iprimus.com.au

Web: www.optionsctc.com.au

Director: Jane Remington-Gurney MA. LCST

Clinics at: Petrie Village Shopping Centre and Multicap Centre, 259 Padstow Rd, Eight Mile Plains.

Please complete this form and return with your booking fee and once received, you will be contacted with an appointment. Please enclose any relevant copies of medical reports, IEP or school reports. All information is dealt with confidentially. There is a square on this form for you to attach a photograph of the person being referred if you so wish.

Client Information Form

Name of child or adult being referred: _____

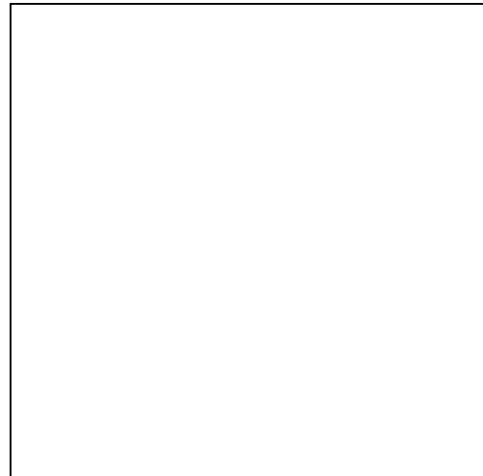
Address: _____

Post Code: _____

Tel: _____ Work Phone: _____

Mobile: _____

Email: _____



Date of Birth: _____ Age at time of Referral to Options: _____

Family Details:

Mother's Name: _____ and occupation _____

Father's Name: _____ and occupation _____

Brothers/Sisters Names/s:

Aged:

Office Use Only: Information requested _____ sent: _____

Information received _____ booking fee received _____

Appointment offered for _____

Assessing Therapist: _____

Therapy scheduled for _____ with _____

Is there a family history of speech, language, literacy or developmental disabilities? If so please describe: _____

School /Workplace Details:

Name of School/work placement: _____ Tel: _____

Address: _____

_____ Post Code: _____

Grade: _____ Teachers'/supervisors' name: _____

Comments: _____

Development and Special issues

1. Were there any significant issues that concerned you regarding:

a) pregnancy yes/no _____

b) delivery yes/no _____

c) ability to suck yes/no _____

d) ability to feed yes/no _____

e) ability to sleep/rest
yes/no _____

2. At approximately what age did the following happen?:

a) babble _____ b) first words _____

c) phrases _____ d) ask questions _____

e) cease to use speech _____ a) sit up _____

b) crawl _____ c) walk _____

d) use a pencil to draw _____ e) go to the toilet independently _____

3. Does the person have any reduced or heightened awareness/sensitivity to the following:-

	heightened	reduced	'normal'	comments
a) pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
b) smell	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
c) touch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
d) light	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
e) taste	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

4. Would you describe the person as a conservative or fussy eater: yes/no

5. Does the person have any of the following:

a) hearing impairment yes/no b) visual impairment yes/no

c) mobility impairment yes/no d) intellectual impairment yes/no

e) difficulty with sounds yes/no f) difficulty making friends yes/no

g) difficulty understanding social rules yes/no

h) difficulty understanding the feelings or emotions of others yes/no

Medical:-

Name of GP: _____ Tel: _____

Name of Paediatrician: _____ Tel: _____

Diagnosis: _____

Provided by: _____

Medication/s: _____

Operations/s: _____

Other Specialists on Child's Support Team:

Name: _____ Role: _____

Name: _____ Role: _____

Name: _____ Role: _____

Name: _____ Role: _____

Referral Information:

I am making the referral to Options because:

I am hoping that the following will be achieved:

If Options is able to offer an intervention program I would **prefer** (please tick)

- | | |
|---|---|
| 1. to attend the Eight Mile Plains Clinic
(Monday and Tuesdays only) | 2. to be seen on an out of clinic basis |
| 3. to attend the Petrie clinic | 4. to be seen on the Sunshine Coast |

Please add any comments or information you feel relevant here:

Initial Consultation Information from Appointment Interview