THELO
ACTIVE THERAPY

Referral Form

Has this referral been discussed with the child's Legal Guardian? ☐ Yes ☐ No

CHILD DETAILS

Family name: _____ Given name: _____ Date of birth: _____

Sex: ☐ Male ☐ Female ☐ Indeterminate

Address: _____

Country of birth: _____

☐ Aboriginal but not Torres Strait Islander origin
☐ Torres Strait Islander but not Aboriginal
☐ Both Aboriginal and Torres Strait Islander
☐ Not Aboriginal or Torres Strait Islander
☐ Not stated / unknown

Alerts/allergies: _____

FAMILY DETAILS

Legal Guardian: ☐ Parent/s ☐ Other: _____

Name: _____ Relationship: _____ Age: _____

Email: _____ Phone: _____ Mobile: _____

Address: _____

Language spoken at home: _____ Interpreter required? ☐ Yes ☐ No

Other significant residential or non-residential Care

Carer name: _____ Age _____ Relationship _____ Contact no: _____

Sibling/s Name: _____ Age _____ Relationship _____ Contact no: _____

Name: _____ Age _____ Relationship _____ Contact no: _____

Name: _____ Age _____ Relationship _____ Contact no: _____

REFERRER DETAILS

Name: _____ Designation/role: _____

Organisation: _____

Address: _____

Email: _____ Phone: _____ Fax: _____

Signature: _____ Date: _____

ABN: 74834700460

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Referral Form continued

Family name: _____ Given name: _____ Date of birth: _____

REFERRAL INFORMATION

Presenting concern and Parent or Legal Guardian's goals: _____

_____

_____

_____

_____

Relevant medical history: _____

_____

_____

_____

_____

Relevant developmental history: _____

_____

_____

_____

_____

Parent/carer/family psychosocial history: _____

_____

_____

_____

_____

OTHER KEY CONTACTS

Other agencies / therapy services involved: _____

_____

_____

Supporting documentation attached? ☐ Yes ☐ No

Email completed form to Thelo Active Therapy: vickiesimos@yahoo.com

ABN: 74834700460

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