Referral Form for a **Child/Adolescent 2024**

Date of Referral:
Referred By: **Phone No:** **Email:** **Reason for Referral:**

Reason for referral/support
☐ NDIS Support Coordination/Case Management
☐ Capacity Building/Advocacy
☐ School Support/Advocacy
☐ Lego Therapy/Club
☐ Support Worker/Mentor
☐ Allied Health – Type:
☐ Other:

Child Details	
Name:	**M** ☐ **F** ☐ **Other** ☐ **DOB:**
Email:	**Address:**
Phone:	**School & Year Level:**
Who does the child live with?	
Are there any court orders in place? If yes, please provide a copy. Y ☐ N ☐ **Type:**	

Current Diagnosis

Family Details

Name 1:	**Relationship to Child:**
Address:	**Phone Number:**
Email:	**Interpreter Needed:** ☐Yes ☐ No
Name 2:	**Relationship to Child**:
Address:	**Phone Number:**
Email:	**Interpreter Needed:** ☐ Yes ☐ No **Language:**
Number of siblings, name and ages:	**Does the client identify as Aboriginal or Torres Strait Islander?** ☐ Yes ☐ No

Is the child in care? Y ☐ N ☐

Organisation:

Name of Caseworker:

Email:

Phone:

Rationale for Support

NDIS

NDIS Number:

Type of management: self ☐ plan ☐ agency ☐

Plan Manager:

Invoices:

Plan Dates:

Funding allocation/type:

There is adequate funding to cover:

☐ weekly support
☐ fortnightly support
☐ monthly support
☐ yearly support
☐ other:

Current Allied Health & Medical Practitioners

Professional	Name	Service/Company	Contact number/Email	Current?	Reason for care
General Practitioner				☐ YES ☐ NO	
Paediatrician				☐ YES ☐ NO	
Speech Therapist				☐ YES ☐ NO	
Occupational Therapist				☐ YES ☐ NO	
Psychologist				☐ YES ☐ NO	
Social Worker				☐ YES ☐ NO	
Class Teacher				☐ YES ☐ NO	
Behaviour Therapist				☐ YES ☐ NO	
Local Area Coordinator (NDIS)				☐ YES ☐ NO	

Other Provider:

Questions or Concerns

Please send to support@awencma.com.au OR take a photo and send to 0434 151 864.

Amanda & Team