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Referral Form for a **CHILD**

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Accredited Social Worker & Education Specialist

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| **Date of Referral:** Click here to enter a date. |
| **Referred By:** Self  Doctor  Other  **Referral Details:** Click to enter text  **Phone No:** Click to enter text  **Reason for Referral:**  Click to enter text |

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| Family Details | |
| **Name:** Click to enter text | **Relationship to Child:** Click to enter text |
| **Address:** Click to enter text | **Phone Number:** Click to enter text |
| **Country of Birth:** Click to enter text | **Interpreter Needed:** Yes  No |
| **Name:** Click to enter text | **Relationship to Child**: Click to enter text |
| **Address:** Click to enter text | **Phone Number:** Click to enter text |
| **Country of Birth:** Click to enter text | **Number of siblings, name and ages:**  Click to enter text |
| **Is the child in care?** Y  N  **Which organisation?** Click to enter text  **Name of Caseworker:** Click to enter text **Phone/Email:** Click to enter text | |

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| **Child Details** | |
| **Name:** Click to enter text | M  F Other  DoB: Click to enter date |
| **Name of current Carer/s:**  Click to enter text | **Address:**  Click to enter text |
| **Phone:**  Click to enter text | **School & Year Level:**  Click to enter text |
| **Who does the child live with?**  Click to enter text | |
| **Are there any court orders in place?**  YN  Please provide a copy | |

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| School History |
| **What was the last grade you attended school?**  Click to enter text  **Were you diagnosed with any learning difficulties at school?** Click to enter text  **Describe your learning experience at school.** Click to enter text |
| **Have you attended TAFE, University or other further study?**  YesNo  **Please explain:** Click to enter text |

**Reason for referral/support**

Difficulties with learning (please comment) Click to enter text

☐ Other (please specify) Click to enter text

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| Physical History |
| **General Health:** Click to enter text |
| **Are you currently under a doctor’s care?**  YesNo  **Reason for care?** Click to enter text  **Phone Number:** Click to enter text |
| **Do you see any other Allied Health Professionals?** Yes No  **Reason for care?** Click to enter text  **Phone Number:** Click to enter text |

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| Your expectations |
| **Why have you decided to come to RIP IT UP Reading?**  **Please explain:** Click to enter text |
| **What would you like to experience that is different from what you are experiencing now?**  **Please explain:** Click to enter text |
| **What would you like to work on in your sessions?**  **Please explain:** Click to enter text |

**Fees**

Are you an NDIS Participant? Agency  Plan  Self

NDIS Number? Click to enter text

If plan managed who with? Click to enter text

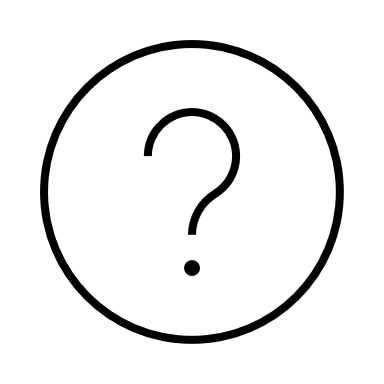
**Referral and Quote information**

RIP IT UP Reading will provide a quote upon receipt of a completed referral form.

RIP IT UP Reading will request all **relevant documentation**, which can be sent via email prior to making your appointment. Such documentation can include previous assessment reports, care plans, file notes.

**Where to send information**

 [contact@ripitupreading.com.au](mailto:contact@ripitupreading.com.au)

 0423584808

**Statement**

I agree that the above is accurate to the best of my knowledge.

I agree for RIP IT UP Reading to contact me at the details given.

**Signature:** Click to enter text **Date:** Click to enter date