SWAN HILL
KIDS THERAPY

SWAN HILL KIDS THERAPY PTY LTD I ABN 35 607 376 894
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passionate about building skills to empower families

HOW TO USE THIS FORM

Take this form to your health care professional for completions and send to Swan Hill Kids Therapy

Email: admin@swanhillkidstherapy.com OR Fax: 03 5032 4821

Name: ______________________ Date of birth: ______________________

Parent's name(s): ______________________ Phone number: ______________________

Address: ______________________ Email: ______________________

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CONDITION / DIAGNOSIS

- ☐ Autism Spectrum Disorder
- ☐ Sensory Processing Disorder
- ☐ ADHD / ADD
- ☐ Intellectual Impairment
- ☐ Hearing Impairment
- ☐ Vision Impairment
- ☐ Cerebral Palsy
- ☐ Down Syndrome
- ☐ Other

PRESENTING CONCERNS

- ☐ Gross Motor Skills
- ☐ Fine Motor Skills
- ☐ Learning Difficulties
- ☐ Handwriting
- ☐ Social Skills
- ☐ Behavioural
- ☐ Self-Regulation Skills
- ☐ Memory
- ☐ Attention / Concentration
- ☐ Self-Care Skills
- ☐ Other Functional Skills

Additional Referral Notes:

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- ☐ Chronic Disease Management Plan (please attach plan)
- ☐ Better Start / Helping Children with Autism (please attach letter for service provider)
- ☐ NDIS - Self Management or Plan Management (please attach plan)

REFERRER'S DETAILS: Date: ______________________

Name: ______________________ Signature: ______________________

Occupation: ______________________ Email: ______________________

PARENT CONSENT: ☐ YES - Consent must be obtained