patches

General Information Form

Client details

Family name

Given names

Other names

Date of birth

Hospital of birth

Biological Mother's name

Ethnicity

Gender ☐ Male ☐ Female ☐ Other

ATSI details ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither

Preferred spoken language

Legal Guardian

Relationship to the client

Residential address

Postcode:

Postal address

Postcode:

Phone number ( )

Email

Person completing referral

Relationship to the client

Phone number ( )

Email

Medicare Card Number

IRN (Place on card)

Expiry date

CRN

Additional details

Previous diagnoses

This referral is for:

If this referral is for Autism please fill out a **Family Referral Form**

- [ ] Paediatrician only
- [ ] Global Developmental Delay
- [ ] ID
- [ ] Autism
- [ ] ADHD
- [ ] Neuropsychology
- [ ] Psychiatry
- [ ] FASD
- [ ] Other:

Are there any current consent orders or legal proceedings in relation to the child?

- [ ] Yes
- [ ] No

Details:

Client in care of Child Protection & Family Support?

- [ ] Yes
- [ ] No

Case worker:

Contact details

Email

Phone number ( )

Carer details

Name

Email

Phone number ( )

Client known to Child Development Services?

- [ ] Yes
- [ ] No

Service:

Contact details

Email

Phone number ( )

Client known to Aboriginal Health Services? ☐ Yes ☐ No Service:

Contact details

Email

Phone number ( )

Development

Has the client had developmental assessments in the past? ☐ Yes ☐ No If yes – Service(s)

Clinician details

Were there any concerns during the pregnancy with the client? ☐ Yes ☐ No

If yes, please list

Did the client's mother use alcohol or other drugs during pregnancy? ☐ Yes ☐ No

If yes, please give details

Was the child born to full term? ☐ Yes ☐ No At how many weeks' gestation were they born?

Did the client have any health concerns at birth or before their first birthday? ☐ Yes ☐ No

If yes, please give details

Were there ever any concerns about the client's development? ☐ Yes ☐ No

If yes, what were you concerned about?

Has the client ever seen any health professionals about their development? ☐ Yes ☐ No

If yes, please list

Are there things that you need to help the client with that you would expect them to be doing by themselves? ☐ Yes ☐ No

If yes, please list

What do you think the client is good at?

Medical

Does the client have any ongoing health concerns? ☐ Yes ☐ No

If yes, please list

Is the client currently taking any medication? ☐ Yes ☐ No

If yes, please give details

Has the client needed to go to hospital? ☐ Yes ☐ No

If yes, please give details including which hospital

How would you describe the client's sleep?

Do they have any difficulties with eating? ☐ Yes ☐ No

If yes, please give details

Speech Pathology

Has the client had Speech Pathology treatment or assessments in the past? ☐ Yes ☐ No

If yes, please give details

Clinician details

Current Concerns (please list)

Speech/Articulation

Language comprehension/ Understanding spoken language

Phonological Awareness/Literacy

Social skills

Stuttering (Length of time)

Voice

Feeding/Eating/Swallowing

Occupational Therapy

Has the client had Occupational Therapy treatment or assessments in the past? ☐ Yes ☐ No

If yes, service(s)

Clinician details

Current Concerns (please list)

Eye-hand coordination

Fatigues during tasks

Difficulty with Pencil/Scissor skills

Difficulty copying or reading from a board

Sensory processing (e.g. difficulty with concentration or fidgety)

Personal care (e.g. toileting, dressing)

Feeding/Eating/Swallowing

Physiotherapy

Has the client had Physiotherapy treatment or assessments in the past? ☐ Yes ☐ No

If yes, service(s)

Clinician details

Current Concerns (please list)

Not reaching motor milestones

Clumsiness

Moving awkwardly

Poor posture

Poor gross motor skills

Poor ball skills

Biomechanical (eg. Hip, foot dysfunction)

Psychology

Has the client had Psychological treatment or assessments in the past? ☐ Yes ☐ No

If yes, service(s)

Clinician details

Current Concerns (please list)

Behavioural concerns

Cognitive difficulties

Related history

Other

Do you have any other concerns? ☐ Yes ☐ No

If yes, please list

What do you hope to get out of a Patches Assessment?

How did you hear about Patches?

Parent/Legal Guardian consent

Your consent gives permission for the child (the client) to be seen by the Patches team until the client is "discharged from the service". You may formally withdraw your consent at any time.

I give my consent for Patches to:

- Undertake assessments and therapy interventions at any site, including schools and clinics
- Obtain, release and exchange reports and relevant information (both written and verbally) with other agencies and individuals as required including:
  - The client's school, including School Psychologist service reports
  - The client's nominated GP
  - Aboriginal Medical Services
  - Any relevant Medical or other Child Development Services
- Make audio and/or visual recordings of the client for assessment, management and therapy purposes
- I understand that Patches is obliged to release relevant information to the Department of Child Protection pertaining to clients in care
- I understand Patches will not administer any medication to the client

Research at Patches

- As well as using the information we collect about the client for their clinical care, we also use it for research and evaluation purposes. For example, we might use the child's data for annual reports about our service, to look at ways we can improve our service, conference presentations and/or research publications.
- Whenever we present information, we do it so that identifying information is not included and you or the client cannot be identified e.g. we do not use their name.
- We sometimes work with researchers from outside our clinic. The research we do is approved by a Human Research Ethics Committee and tends to look at groups of people rather than just one person (e.g., what was the average age of our clients).
- While there are no direct benefits to you or the client from letting Patches use the client's information for research, this information might help us improve our understanding and treatment of various psychological and medical conditions, potentially benefiting future clients.
- It is ok if you do not want the client's information used for research purposes.
- You can change your mind at any time after signing this Consent Form.

Confidentiality

All medical records are stored securely. Only Patches staff members have access to these records, unless the law requires us to disclose it.

- Consistent with State Health policy and legal standards, all medical records are kept for a minimum of 7 years after the death of a client and then destroyed
- The client's information will be used as described in this form and not otherwise disclosed (unless disclosure is required by law).

If you have any questions, we can talk to you before you sign this consent form.

- I have read and understood the information provided above. Any questions that I have asked have been answered to my satisfaction.
- I understand that if I have further questions or I wish to withdraw my consent at a later date, I may contact Patches on (08) 6280 1259.
- I give my permission for Patches to enter the client's information into a database with the understanding that any information used for reports, conference presentations and/or research publications will be de-identified.
- I understand that the information I provide will be kept in the strictest confidence by Patches, unless obliged to release by law.
- I understand that, if I wish, I may ask for a copy of this Information and Consent Form.

Signatures

Name of child/client			
Legal Guardian Name			
Legal Guardian Signature		Date	

Send the signed and completed form to:

WA Email: diagnosis@patches.com.au
Fax: 08 6208 3202

NT Email: ntdiagnosis@patches.com.au
Fax: 08 6208 3202