|  |  |  |
| --- | --- | --- |
| **PERSONAL DETAILS** | | |
| **Child’s Full Name:** | | **Date of Birth:** |
|  | |  |
| **Parent, Legal Guardian or Representative:** |  | |
| **Does the child live with parents or legal guardian?** | Yes  No | |
| **Identify as Aboriginal or Torres Strait Islander?** | Yes  No | |
| **Current Address:** |  | |
| **Usual Address:** |  | |
| **Where to find the child?** *(Name of playgroup, school, institution etc.)* |  | |
| **Phone:** |  | |
| **Email:** |  | |
| **How is best to contact the family?** (phone/through clinic/through community navigator) |  | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **CONSENT TO EXCHANGE INFORMATION** | | | | |
| Do you consent to the referrer sharing information about your child with the Early Childhood Support Team? | | | | |
| ¨ **Yes**, I consent | | ¨ **No**, I do not consent. I will provide the information myself | | |
| Please sign and date | |  |  |  |
|  |  |  |  |  |
| Parent, Legal Guardian or Representative Signature | ­­Date |

### Reason for Referral:

|  |  |  |  |
| --- | --- | --- | --- |
| Please tick | |  | **COMMENTS** |
| Talking | Using hands |  |
| Moving | Eating |  |
| Behaviour | Toileting |  |
| Playing | Sleeping |  |
| Getting dressed | Listening |  |
| Paying Attention | Learning |  |
| Feelings |  |  |

|  |  |  |
| --- | --- | --- |
| **REFERRER - Contact Details** | | |
| **NAME:** | **POSITION:** | |
|  |  | |
| **EMAIL** | | **PHONE** |
|  | |  |

|  |  |  |
| --- | --- | --- |
| **EARLY CHILDHOOD SUPPORT - Contact Details** | | |
| **NAME:** | **POSITION:** | |
|  |  | |
| **EMAIL:** | | **PHONE:** |
| **kimberleysupports@kamsc.org.au** | | **(08) 9194 0318** |