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| --- |
| **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) |  |

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|  **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** |
|  |  |

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