Referral for Autism Intervention Services

Autism Specific Early Learning & Care Centre
aselcc
ACN 614 663 526
North West Tasmania

Don't like filling in forms or having trouble with this document?

Please call 1300 278 445 and ask to speak to an intake team member who will complete a brief interview by phone.

Child Details

Surname: _____ First Name: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female

Australian Residency Status: ☐ Citizen ☐ Permanent ☐ Visa: (details:) _____

Primary Language Spoken at home: ☐ English ☐ Other: _____

Is the child of Indigenous Origin: ☐ Aboriginal Australian ☐ Torres Strait Islander

☐ Australian South Sea Islander ☐ Not Indigenous ☐ Do not wish to answer

Does the child come from a culturally and linguistically diverse background?

☐ No ☐ Yes (details:) _____

Child's diagnosis: (please tick all relevant)

	Date:	Diagnosis given by:
☐ Autism Spectrum Disorder		
☐ Autistic Disorder		
☐ Asperger's Disorder		
☐ Pervasive Development Disorder - Not otherwise Specified		
☐ Other: _____		

If the child does not have a definite diagnosis, please indicate ASD-like symptoms
(please tick all that the child displays, if you are unsure and would like clarification, please contact the centre on the number below).

- ☐ Delayed development, particularly of language skills
- ☐ Solitary play and withdrawal from others
- ☐ Lack of imaginative play
- ☐ Disinterest in other people's attempts at communication
- ☐ Difficulty with changes in routine
- ☐ Lack or absence of eye contact
- ☐ Repetitive behaviours or obsessions which, if interrupted may provoke challenging behaviours
- ☐ Repetitive movements
- ☐ Preoccupation with parts of objects
- ☐ Inflexible adherence to particular routines or rituals
- ☐ Extraordinary talent or brilliance in specific skills
- ☐ Inappropriate body language

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Parent/Guardian/Person Responsible details:

Relationship: Parent ☐ Guardian ☐ Foster Parent ☐ Other ☐ _____

Mr ☐ Mrs ☐ Ms ☐ Surname: _____ First Name: _____

Gender: Male ☐ Female ☐ Other ☐

Email: _____

Address: _____ P/code: _____

Phone: _____

Preferred method of contact: Call ☐ Text ☐ Email ☐

Are there any court orders or parenting orders in place for the child?

No ☐ Yes ☐

If YES, please provide details. You will need to provide a copy at your first appointment:

Second Parent/Guardian/Person Responsible details: (if applicable)

Relationship: Parent ☐ Guardian ☐ Foster Parent ☐ Other ☐ _____

Mr ☐ Mrs ☐ Ms ☐ Surname: _____ First Name: _____

Gender: Male ☐ Female ☐ Other ☐

Email: _____

Address: _____ P/code: _____

Phone: _____

Preferred method of contact: Call ☐ Text ☐ Email ☐

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Therapy Intervention History

What interventions is the child receiving or have they received in the past?
(please provide copies of reports)

Early Childhood Intervention Service (ECIS) Yes ☐ No ☐
If **YES**, who provided the service?

When? From: _____ To: _____

Speech Pathology Yes ☐ No ☐
If **YES**, who provided the service?

When? From: _____ To: _____

Occupational Therapy Yes ☐ No ☐
If **YES**, who provided the service?

When? From: _____ To: _____

Psychology Yes ☐ No ☐
If **YES**, who provided the service?

When? From: _____ To: _____

Psyiotherapy Yes ☐ No ☐
If **YES**, who provided the service?

When? From: _____ To: _____

Dietician Yes ☐ No ☐
If **YES**, who provided the service?

When? From: _____ To: _____

Other _____ Yes ☐ No ☐
If **YES**, who provided the service?

When? From: _____ To: _____

Other _____ Yes ☐ No ☐
If **YES**, who provided the service?

When? From: _____ To: _____

Any other services and supports involved with the child?

(Complete ALL applicable)

School

Service Name: _____

Key Contact Name: _____

Phone: _____

Child Care

Service Name: _____

Key Contact Name: _____

Phone: _____

General Practitioner

Service Name: _____

Key Contact Name: _____

Phone: _____

Paediatrician

Service Name: _____

Key Contact Name: _____

Phone: _____

Respite

Service Name: _____

Key Contact Name: _____

Phone: _____

Other

Service Name: _____

Key Contact Name: _____

Phone: _____

Other

Service Name: _____

Key Contact Name: _____

Phone: _____

Is there any other important information we should know about the child or family?

Reason for Referral

Please indicate your main reasons for referral by marking priority areas for the child and family:

Communication

- ☐ Having a way to communicate
- ☐ Understanding what is being said to them/following instructions
- ☐ Eye-contact/looking towards the speaker
- ☐ Requesting/accepting help
- ☐ Greeting/initiating communication
- ☐ Increasing complexity of communication (e.g. more words, longer sentences, conversation skills, correct grammar etc.)
- ☐ Speaking clearly/fluently
- ☐ Using appropriate non-verbal communication (e.g. facial expression, tone of voice, gestures etc.)
- ☐ Other: _____
- ☐ Other: _____

Social Participation

- ☐ Taking turns/sharing
- ☐ Waiting
- ☐ Being gentle
- ☐ Motivating cooperation/participation
- ☐ Playing with others (e.g. parents, siblings, other children)
- ☐ Feeling close/connected to each other
- ☐ Spending more time together as a family
- ☐ Eating together/mealtimes
- ☐ Making/keeping friends
- ☐ Understanding others' emotions and nonverbal communication (e.g. facial expression, tone of voice, gestures)
- ☐ Understanding social situations/social rules
- ☐ Other: _____
- ☐ Other: _____

Self-care

- ☐ Eating and drinking (e.g. using utensils, eating a variety of foods, chewing, swallowing)
- ☐ Getting dressed/tolerating clothes
- ☐ Grooming activities (e.g. washing hair, brushing teeth/hair, bathing)
- ☐ Toileting
- ☐ Other: _____
- ☐ Other: _____

Emotional Regulation and Sensory Processing

- ☐ Being touched/soothed
- ☐ Coping with sensory challenges (e.g. sounds, textures, smells, tastes, movement, "busy" environments)
- ☐ Staying calm/emotional regulation
- ☐ Sleeping/bedtime
- ☐ Giving up dummy/bottle
- ☐ Not hurting themselves
- ☐ Understanding/managing own emotions (e.g. happy, sad, stressed, worried, frustrated)
- ☐ Coping with routines/transitions/change/separation
- ☐ Other: _____
- ☐ Other: _____

Play and Learning

- ☐ Being touched/soothed
- ☐ Occupying self/knowing how to play with a range of toys
- ☐ Concentrating
- ☐ Working things out (e.g. puzzles, simple construction, counting, sequences, early numeracy)
- ☐ Early literacy skills (e.g. enjoying books, recognizing letters and sounds in words)
- ☐ Pre-academic fine motor skills (e.g. gluing, cutting, painting, building)
- ☐ Drawing/writing
- ☐ Playing outside/gross motor skills (e.g. climbing, bikes, swings, swimming, trampoline, ball skills, jumping, balance)
- ☐ Pretend play
- ☐ iPad/computer skills
- ☐ Organising belongings (e.g. toys, bag, bedroom, desk)
- ☐ Attending/support at childcare or school
- ☐ Coping with/participating in group times
- ☐ Solving everyday problems – What to do if… (e.g. something doesn't work/is finished/is missing)
- ☐ Other: _____
- ☐ Other: _____

Community Access and Participation

- ☐ Travelling safely
- ☐ Staying safe (e.g. road sense, stranger danger, wandering, "escaping", climbing)
- ☐ Going shopping
- ☐ Going out (e.g. to parks, restaurants, family outings, religious services)
- ☐ Going to appointments (e.g. doctor, dentist, hairdresser)
- ☐ Using community facilities / joining clubs and activities (e.g. play group, sport, hobby)
- ☐ Other: _____
- ☐ Other: _____

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Parent/Carer Information Needs

- ☐ Understanding/managing behaviours
- ☐ Organising medical/diagnostic tests
- ☐ Assessment – knowing more about my child's strengths and challenges
- ☐ School options
- ☐ Telling/educating others about the child/their diagnosis (e.g. siblings, grandparents, friends, teachers)
- ☐ Giving child information (e.g. about diagnosis, changes like moving house/school, new sibling, separation, illness, death)
- ☐ Finding suitable equipment and resources to support my child's needs
- ☐ Linking to other services/funding options/rebates
- ☐ Other: _____
- ☐ Other: _____

Family and Parent/Carer Support

- ☐ Meeting other parents/carers
- ☐ Having someone to talk to about our challenges and successes
- ☐ Managing own stress/having some "me" time
- ☐ Having more time as a couple/with other children in the family
- ☐ Involving other family members (e.g. siblings, grandparents)
- ☐ Extra help/support for family (e.g. managing in times of crisis, support for siblings)
- ☐ Respite care
- ☐ Other: _____
- ☐ Other: _____

Acknowledgement: Goals listed above are taken from Autism Queensland's Family Goal Setting Tool – Autism Spectrum Disorder (ASD) Version (2013)

Please indicate any other issues/areas of concern that you hope will be addressed through your intervention program?

Availability and Preferred Location for Intervention

For children prior to school age (i.e. kinder age and younger):
Your child may be eligible for the ASELCC's centre based program in Burnie or Satellite Centres in Smithton, Devonport or King Island. The ASLECC comprehensive multidisciplinary centre based program is funded by the Australian Government's Department for Social Services and is available to families at the cost of childcare only.

Are you interested in the ASELCC's centre based programs? Yes ☐ No ☐

Please indicate preferred time for intervention

Monday	Tuesday	Wednesday	Thursday	Friday
AM ☐ PM ☐	AM ☐ PM ☐	AM ☐ PM ☐	AM ☐ PM ☐	AM ☐ PM ☐

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Please indicate preferred location for intervention

☐ **ASELCC** (Burnie) ☐ **Home** ☐ **Childcare Centre/School** ☐ **Other:** _____

Do you have any other specific requests or preferences about your child's intervention?

What funding will be used to pay for your ASELCC Therapy Plus intervention?

Please note if you fail to attend an appointment you will be required to pay the cancellation fee as most funding programs do not pay for cancellations.

☐ Helping Children with Autism (please provide a copy of your letter of introduction)
☐ Better Start for Children with Disability (please provide a copy of your letter of introduction)
☐ National Disability Insurance Scheme (NDIS) NDIS Number: _____
☐ Medicare (please provide a copy of your GP or Paediatrician plan)
☐ Self-funded
☐ Other: _____

PLEASE NOTE: The ASELCC Centre Based Program incurs childcare fees only which can be reduced considerably for most families. Parents/guardians will incur this cost.

Referrer details: (if not parent/guardian)

Surname: _____ First Name: _____ Date of Referral: _____

Relationship: _____

Organisation: _____ Phone: _____

Email: _____

Address: _____ P/code: _____

Parent/Guardian Consent

☐ I, _____ (parent/guardian) give consent for _____ to make a referral to the ASELCC, for the referrer to provide relevant information (including reports) to support this referral and for my information about my referral to be shared, if required, at the North West Local Service Provider Group.

OR

☐ I, _____ (parent/guardian) have self-referred to the ASELCC and I consent for information about my referral to be shared, if required, at the North West Local Service Provider Group.

Signature: _____ _____
Parent/Carer Date:

Return to:
North West Tasmania Autism Specific
Early Learning and Care Centre
Level 1, 34 Alexander Street, Burnie TAS 7320

aselcc@stgiles.org.au
Phone: 03 6454 1222