



DAT referrals require two professionals (e.g. Medical Practitioners, Allied Health Professionals, CHaPS Nurses, NDIS Early Childhood Partners, ECIS staff and the Inclusion Support staff) to be in agreement about the appropriateness of the referral. Details of these professionals should be included in Referring Professional Section below. Paediatricians and Psychiatrists may refer without a second professional. CHaPS Nurses may refer for SACS assessment (only) without a second professional. Parents/carers wishing to have child assessed will need to arrange for referral by discussing concerns with the professionals involved with their child.

ID #

Referral Date:

**PLEASE COMPLETE ALL PAGES OF THIS FORM GIVING AS MUCH DETAIL AS POSSIBLE**

This referral has been discussed with the parent/caregiver

**Personal details of the client being referred**

SURNAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: Male:  Female:

Aboriginal/Torres Strait Islander  Culturally and Linguistically Diverse Background

**Parent/Guardian/Person Responsible details:**

Primary Carer's Name(s): \_\_\_\_\_

Email: \_\_\_\_\_

Address: \_\_\_\_\_ State: \_\_\_\_\_ P/code: \_\_\_\_\_

Home: \_\_\_\_\_ Mob: \_\_\_\_\_ BH: \_\_\_\_\_

Secondary Carer's Name(s): \_\_\_\_\_

Email: \_\_\_\_\_

Address (if different from above): \_\_\_\_\_ State: \_\_\_\_\_ P/code: \_\_\_\_\_

Childcare/playgroup: \_\_\_\_\_ Childcare Educator: \_\_\_\_\_

**PAEDIATRICIAN** (please initiate referral if not already accessing): \_\_\_\_\_

**Please tick if the child has been referred/is currently or has received:**

General practitioner: \_\_\_\_\_

Hearing assessment (date if known): \_\_\_\_\_

Other: e.g. ECIS, Child health nurse (Please list all): \_\_\_\_\_

Speech Pathology (provide details): \_\_\_\_\_

Occupational therapy (provide details): \_\_\_\_\_

Physiotherapy (provide details): \_\_\_\_\_

**Reason for Referral** (please select only one)

Psychology assessment (provide information about reason for referral):

**Autism Spectrum Disorder Assessment** (Complete information overleaf):

**Multi-disciplinary Diagnostic Assessment**

(Differential diagnosis requiring Psychologist, Speech Pathologist and Occupational Therapist): **\*NORTH ONLY**

**Social attention and communication surveillance (SACS) referral.**

(Please attach a copy of current (and any previous) SACS Assesment: **(CHaPS ONLY)**):

### Social Attention and Communication observations

- Hasn't reached appropriate milestones for language
- Recites strings of words or scripts
- Doesn't seem interested in other children
- Difficulties engaging in reciprocal back-and-forth play
- Absent, inconsistent, fleeting or poorly integrated eye contact
- Doesn't/rarely turn when parent or other calls his/her name
- Doesn't/rarely smiles in response to another person
- Uses an adults hand like a tool
- Doesn't/rarely looks at you when you are talking or playing
- Does not show things of interest e.g. only shows things for the purpose of asking for help
- Does not play simple social imitation games e.g. peek-a-boo, pretending to brush hair
- Doesn't/rarely points with his/her finger to things out of his reach
- Doesn't/rarely looks to where others are pointing or looking
- Inconsistent responses to instructions/directions
- Limited use of gesture e.g. shaking or nodding of head, waving, shoulder shrug

Please provide examples based on those ticked above:

### Play and Behavioural observations

- Attends more to parts of objects (e.g. wheels)
- Has odd or repetitive movement patterns
- Has limited or absent pretend play
- Doesn't/rarely imitates others
- Engages in non-functional play with objects (e.g. spinning wheels for long periods of time)
- Plays with toys in the exact same way each time
- Has a preoccupation or a very narrow range of interests
- Strongly attached to a specific, unusual object(s) (not a comforter)
- Insists on following rigid routines
- Extreme difficulty with transitions/changes in activity
- Shows odd or unusual responses to sensory input/s (e.g. extreme distress to sounds or touch)
- Demonstrates unusual sensory exploration (e.g. licking or sniffing objects)

Please provide examples based on those ticked above:

Any other development and/or behaviour concerns: (e.g. sleep issues)

#### Referring Professional

Professional's Name: \_\_\_\_\_

Position and Organisation: \_\_\_\_\_

Address: \_\_\_\_\_ State: \_\_\_\_\_ P/code: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

#### Supporting/Second Referring Professional

Professional's Name: \_\_\_\_\_

Position and Organisation: \_\_\_\_\_

Address: \_\_\_\_\_ State: \_\_\_\_\_ P/code: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

#### Return to:

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