

**GC #** (internal use) \_\_\_\_\_ **Referral Date** \_\_\_\_\_

**PLEASE COMPLETE BOTH SIDES OF THIS FORM GIVING  
AS MUCH DETAIL AS POSSIBLE**

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.

## Child's Details

Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Gender: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

Does the Child identify as Aboriginal, Torres Strait Islander?  Yes  No

Language(s) spoken at home: \_\_\_\_\_ Interpreter required?  Yes  No

Court Orders:  Yes  No Details: \_\_\_\_\_

Australian Citizen or Permanent Resident:  Yes  No Visa Number \_\_\_\_\_

Paediatrician (please initiate referral if not already accessing) \_\_\_\_\_

## Primary Parent / Guardian / Person Responsible Details

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_ Mobile Number \_\_\_\_\_

Email Address \_\_\_\_\_

## Secondary Parent / Guardian / Person Responsible Details

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address (if different from above) \_\_\_\_\_

Telephone \_\_\_\_\_ Mobile Number \_\_\_\_\_

Email Address \_\_\_\_\_

## Please tick if the child has been referred to/is currently seeing or has received:

Paediatrician: \_\_\_\_\_

General Practitioner: \_\_\_\_\_

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

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

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

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

Early Childhood approach (NDIS): \_\_\_\_\_

Other e.g. ECIS, Child Health Nurse (please list all): \_\_\_\_\_

## Referral for Developmental Assessment Team

### Reason for Referral

All the below assessments are for diagnostic purposes, we are unable to complete assessments to solely support funding applications for the Education Department and/or the NDIS.

- Psychology Assessment** – Developmental assessment and/or exploration of behavioural concerns relating to attachment, anxiety, ADHD or Global Developmental Delay/Intellectual Disability.

- Multi-Disciplinary Autism Diagnostic Assessment** – Comprehensive assessment of social communication skills and behaviour where Autism Spectrum Disorder is suspected.

- Multi-Disciplinary Diagnostic Assessment** – Comprehensive assessment of development e.g. sensory processing, motor skills, play, adaptive skills, problem-solving, where Autism Spectrum Disorder is NOT suspected.

- Social Attention and Communication Surveillance (SACS) referral** – up to 30 Months of age.  
 Please attach or outline SACS Screening Tool results.

### 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
- Doesn't show things of interest (e.g. only shows things for the purpose of asking for help)
- Doesn't 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/her reach
- Doesn't/Rarely looks to where others are pointing or looking
- Inconsistent responses to instruction/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)

**Primary Referring Professional**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Position/Organisation: \_\_\_\_\_ Email: \_\_\_\_\_

Address: (if different from above) \_\_\_\_\_

Signature: \_\_\_\_\_

**This referral has been discussed with the parent/caregiver**

**Secondary Referring Professional (if required)**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Position/Organisation: \_\_\_\_\_ Email: \_\_\_\_\_

Address: (if different from above) \_\_\_\_\_

Signature: \_\_\_\_\_

**Return to St Giles – referrals@stgiles.org.au**

<u>North</u> – PO Box 416, Launceston, TAS 7250	☎ +61 3 6345 7333	Fax: +61 3 6345 7373
<u>South</u> – PO Box 45, New Town, TAS 7008	☎ +61 3 6238 1888	Fax: +61 3 6238 1818
<u>North West</u> – 11 Queen St, Burnie, TAS 7320	☎ +61 3 6454 1222	