



Request for School Age Therapy Services (SATS)

Please ensure all sections are complete to minimise delay in processing your application.

PLEASE PRINT

Given names: _____

Date of Birth: ____/____/____

SURNAME: _____

Gender: Male Female

Parent / Guardian / Foster Parent (please circle)
Mr/ Mrs / Ms (please circle)

Address: _____

Full name/s _____

_____ Postcode: _____

Telephone :

Home: _____

Work: _____

Are you a Permanent Resident of Australia? Yes / No

Mobile: _____

Is your family in Australia on a Work Visa? Yes / No
provide details _____

e-mail: _____

What is the child's diagnosis, provide a description of the child's disability.

Please attach any relevant medical diagnostic and therapy reports.

What type of support are you seeking from this SATS referral?

School name: _____ Learning Centre / ESC

Year _____

School address: _____

Postcode _____ Phone: _____

Referral completed by:

Name: _____ Title _____

Address: _____

Contact numbers: _____

Name of other agencies known to be involved: _____

ie. Early Intervention services provider

THERAPY HISTORY

Has the child ever received:	Physiotherapy Yes <input type="checkbox"/> No <input type="checkbox"/>	Occupational Therapy Yes <input type="checkbox"/> No <input type="checkbox"/>	Speech Pathology Yes <input type="checkbox"/> No <input type="checkbox"/>
If Yes: Who provided the service?			
When?	From: To:		

PARENT / GUARDIAN CONSENT

I, _____, parent /guardian of
PLEASE PRINT (Name of Parent / Guardian)

PLEASE PRINT (Childs name)

- Authorise the collection and release of therapy service records, reports and sensitive information as defined in the Privacy Amendment (Private Sector) Act 2000, regarding my child to the relevant school authority, Disability Services Commission or Princess Margaret Hospital as appropriate.
- Authorise the collection and release of any therapy records and information regarding my child to Rocky Bay School Age Therapy Services (SATS).
- Authorise release of confidential psychological assessment reports regarding my child to Rocky Bay School Age Therapy Services (SATS).
- Give permission for my son/daughter to participate in services conducted by the Rocky Bay School Age Therapy Services (SATS) program, and
- Agree to work in partnership with Rocky Bay School Age Therapy Services (SATS) for meeting outcomes for my child.

SIGNATURE: _____ **DATE** _____

Return to:

Tracey Delamare,
Manager
Rocky Bay
School Age Therapy Services (SATS)

Rocky Bay
Post Office Box 53
MOSMAN PARK WA 6912
☎ 9383 6149
Fax: 9384 5757

Rocky Bay Office use only

Date Received:	
Eligible <input type="checkbox"/> sign & date	Ineligible <input type="checkbox"/> sign & date
CIMS	<input type="checkbox"/>
List 200	<input type="checkbox"/>
Client Register	<input type="checkbox"/>
Letters:	Sch <input type="checkbox"/> P <input type="checkbox"/> Ref <input type="checkbox"/>
Client Package mailed <input type="checkbox"/>	Date:
Faxed to SATS <input type="checkbox"/>	Date: