

Please ensure **all** sections are completed

PLEASE PRINT Student full name

Given Names: _____

SURNAME: _____

Sex: Male Female

Parent / Guardian Names: Mr/ Mrs / Ms

Home Phone: _____

Is the student:

- receiving Carers Allowance?
- receiving Disability Support Pension?
- registered with Disability Services Commission?
- of Aboriginal or Torres Strait Islander Descent?

In which **country** was the student born?

What is the main **language spoken** in the student's home?

Provide a brief description of the student's disability

Please tick : New Referral Re-referral

Date of Birth: ____/____/____

Address: _____
_____ P/Code: _____

Work Phone: _____

Mobile no: _____

Yes **Card No.** _____ No

Yes **Card No.** _____ No

Yes **Card No.** _____ No

Yes **Card No.** _____ No

*(include **diagnosis** where possible, eg. cerebral palsy, autism, spina bifida, intellectual disability):*

Are you in receipt of compensation?

Yes No

If yes, please state type of compensation

Identified problems / reason for therapy request:

What is required from Rocky Bay SATS?

Name other agencies known to be involved: _____

THERAPY HISTORY

Has the student ever attended:	Physiotherapy		Occupational Therapy		Speech Pathology	
	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If Yes: Who provided the service?						
When did they receive the service?	From: To:					
(for frequency specify weekly, monthly, yearly review etc..)	Frequency:					
Are they still having therapy?						

