Rocky Bay
HEALTH + COMMUNITY

Early Start Intervention Program (ESIP)

Referral Form 2021

The Early Start Intervention Program aims to provide intensive, evidence based multidisciplinary therapy services to children less than 5 years old with evidence of significant developmental delay and/or regression and other associated risk factors.

To assess eligibility for the ESIP program, please complete the below referral form.
Any relevant supporting documentation can be sent via **Email**: ESIP@rockybay.org.au
Phone: 08 6499 1438 **Fax**: 08 9383 1230 or **Mail**: PO Box 53, Mosman Park WA 6192

Participant Details

Child's Name: _____

Child's Date of Birth: _____ Gender: ☐ Male ☐ Female

Home Address: _____

Suburb: _____ Post Code: _____

Primary Caregiver Details

Parent/Guardian Name: _____

Relationship to child: _____

Phone No: _____ Mobile: _____

Email Address: _____

Main language spoken at home: ☐ English ☐ Other Please specify: _____

Interpreter Required: ☐ Yes ☐ No Preferred time for contact: ☐ AM ☐ PM

Is the child a permanent Australian resident?	☐ Yes	☐ No
Is the child currently accessing funding under the NDIS?	☐ Yes	☐ No
Does the child identify as an Aboriginal or Torres Strait Islander?	☐ Yes	☐ No
Does the primary caregiver identify as an Aboriginal or Torres Strait Islander?	☐ Yes	☐ No
Is the child currently under the care of the Department of Child Protection and Family Support (CPFS)?	☐ Yes	☐ No

Referral Details

Primary Reason for Referral: _____

Does the child have a diagnosed disability, health concern and/or medical condition(s):

_____

Please identify and mark the following risk factors or criteria that are applicable:

_____

- ☐ Significant developmental delay and/or regression
- ☐ Children with two or more of the following risk factors including:
  - ☐ Abnormal muscle tone including hypertonia, hypotonia, dystonia and/or spasticity
  - ☐ Congenital Malformations or anomalies including craniofacial anomalies
  - ☐ Diagnosed hearing and/or visual impairment
  - ☐ Feeding Difficulty/Failure to Thrive (FTT)
  - ☐ Hydrocephalus
  - ☐ Seizures/Epilepsy
  - ☐ Microcephaly
  - ☐ Musculoskeletal Anomalies i.e. short stature, limb deformity, spinal deformity
  - ☐ Proximal and/or distal significant muscular weakness or muscle atrophy
  - ☐ Prenatal Intrauterine Growth Restriction (IUGR)

Referrer Details

Please indicate who completed this referral form:

☐ Parent/Guardian ☐ Medical Professional ☐ Allied Health Professional

☐ Other please specify: _____

If medical, health professional or other, please complete the following:

Name of Referrer: _____

Profession: _____ Place of Work: _____

Contact Phone Number: _____ Email: _____

☐ I (the referrer) declare that I have received consent from the parent/guardian of the child being referred to share client information with Rocky Bay, and the parent/guardian has consented to being contacted by Rocky Bay to obtain further information as required.

☐ I (the referrer) have attached relevant supporting documentation including written reports and clinical assessments with permission from the parent/guardian of the child.

Submit Form