Rocky Bay
HEALTH + COMMUNITY

Form completed date:

Early Start Intervention Program (ESIP)

Referral Form 2023

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 signs, symptoms or risk factors.

To assess eligibility for the ESIP, please complete the below referral form and send this document and any supporting documentation to ESIP@rockybay.org.au 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/regression or concern in two or more areas (i.e. mobility, self-care, communication
- ☐ 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.

How did you hear about us? _____