Early Mealtime Service
Referral form

Date

This form is for those seeking mealtime therapy services delivered by experienced clinical lead therapists for children under seven (7) years of age.

For more information on this service please contact us at info@abilitywa.com.au or call 1300 106 106.

Information about referring

Part 1: Eligibility

To be eligible for Early Mealtime Service, the child needs to be identified as being at risk and in need of specialist mealtime therapy support.

Some examples of risk factors include:

- Sign/s of distress during mealtimes such as coughing, choking or vomiting
- Significant changes in food intake and or weight
- Eating a different meal from the family at two (2) years old
- Extreme sensitivity to tastes, smells, textures or the way food looks or feels (sensory based feeding difficulties)

This service is available to children with/without a diagnosis. We will consider all children despite current funding and will consider children under the NDIS if they do not have adequate funding to support current feeding goals.

Part 2: Service area

This service is available in the North Metropolitan area. We are unable to support referrals south of the city at this point in time.

Please provide any supporting documentation you have that will assist us to assess this referral.

Please send this form to info@abilitywa.com.au.

You will receive a response email to confirm that we have received the referral. You will also receive a copy of the child's initial assessment report and exit report if the family consent to share the information.

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Details of individual being referred

Child's details:

First name:		Last name:	
Date of birth (DD/MM/YY):		Sex:	◯ Male ◯ Female
Centrelink number:			

Primary carer details:

First name:		Last name:	
Relationship to child:			
Home address:			
Suburb:		Post code:	
Email address:		Phone number:	
Spoken language:		Interpreter required:	◯ Yes ◯ No

Additional carer details:

First name:		Last name:	
Relationship to child:			
Contact details same as the above:	◯ Yes ◯ No		
Home address:			
Suburb:		Post code:	
Email address:		Phone number:	
Spoken language:		Interpreter required:	◯ Yes ◯ No

Is the child of Aboriginal and/or Torres Strait Islander origin?

◯ Yes ◯ No

Does the child have involvement with Child Protection and Family Support (CPFS)?

◯ Yes ◯ No

Are there signs of parental stress, anxiety and/or depression?

◯ Yes ◯ No

Are there any concerns for the safety of the therapist entering this home environment?

◯ Yes ◯ No

Medical history

Reason for referral

Please clearly outline the reason why the child requires mealtime therapy support and include any previous support accessed.

More information

Please complete the below and provide details where necessary.

Confirmed neurological insult on MRI or neurological examination

◯ Yes ◯ No

If yes, please provide details:

Born prematurely

◯ Yes ◯ No

Number of weeks: Birth weight:

Enteral/tube feeding

◯ Yes ◯ No

If yes, please provide details:

Weight gain or loss

◯ Yes ◯ No

If yes, please provide details:

Vision or hearing concerns

◯ Yes ◯ No

If yes, please provide details:

Current health or deformity risk, or significant pain

◯ Yes ◯ No

If yes, please provide details:

Experiences seizures

◯ Yes ◯ No

If yes, please provide details:

Diagnosed disability

◯ Yes ◯ No ◯ Waiting to access NDIS

Please provide details:

Does the child have any other health concerns or relevant information to support the referral?

Please provide details below.

Does the child have any medical or therapy reports to be included?

◯ Yes ◯ No

Please ensure any relevant reports are included when returning this referral form.

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Referrer details

First name:		Last name:	
Relationship to child:			
Address:			
Suburb:		Post code:	
Email address:		Phone number:	

Medical practitioner details

Same as referrer details above? ◯ Yes ◯ No

If no, please provide details below.

Full name:			
Practice name:			
Address:			
Suburb:		Post code:	
Email address:		Phone number:	

Consent for referral

I/we understand that the personal information and supporting evidence/documentation provided on this form is collected for the purpose of determining my child's eligibility to receive services.

Child's name:		Date of birth:	
Parent/legal guardian's name:			

Use of information

I/we give consent to Ability WA to access reports and information regarding to assessment if he/she is eligible to receive services.

_____ _____

Parent/legal guardian full name Parent/legal guardian signature

OR

◯ Verbal consent provided by parent/legal guardian.

Date: _____