De Silva KIDS CLINIC

OT (AHA) Intake form

Allied Health Assistant Inclusion Criteria	Allied Health Assistant Exclusion Criteria
• Paediatric Clients, aged 2-17 years of age • Clients experiencing functional difficulties that negatively impact their participation in everyday life, with the following goals; o **Play and Social Skills (**turn-taking, win/lose, creating and maintaining friendships) o **Fine Motor skills** (handwriting, cutting, shoelaces, dressing and more) o **Gross Motor Skills** (hopping, throwing and catching a ball) o I**ndependence building** (budgeting, shopping, cooking). o **Executive Functioning** (problem solving, following instructions, understanding others perspectives) o **Visual-Motor Skills** (shoelaces, handwriting)	• Emotional Regulation, Sensory Regulation and challenging behaviour management as main goals. • Toileting referrals as the sole concern. • Feeding referral. • Physical disabilities; Cerebral palsy, Pigeon toed and Gait issues - **Contact Physio or specialised OT.** • Driving Assessments. • Developing Behaviour Support Plans**.** • Accessing services using "Better Access to Mental Health Plan" or Medicare EPC. • No functional goals identified. • Assistive Technology Recommendations and Equipment prescriptions • Functional Capacity or Sensory Assessment.

Allied Health Assistant's are working under the supervision of an OT, but do not have the scope to provide all of the interventions/assessments OT's do, as outlined in the exclusions above. If on the initial session with one of our Occupational Therapists, it is deemed your child meets any of the exclusion criteria, they will be placed on a waitlist for OT rather than AHA. Please tick the box below to confirm your understanding of exclusion criteria:

Yes, I have read and understand the exclusion and inclusion criteria ☐

Please see OT Australia's "find an OT" page for specialisations: **https://otaus.com.au/find-an-ot**

Please complete as much information as possible and send to info@desilvakc.com

Date of Completion:		**Your Name:**	

Client's Details			
Full Name		**Date of Birth**	
Address (incl. Postcode)			
Gender Identity		**Cultural Identity**	
Preferred Language		**Interpreter Required?**	
Educational Setting *(School, Childcare, Kinder)*			
Health Conditions *(diagnoses, medications)*			

Preferred Contact Person Detail	
Contact Name	
Relationship Type	
Email Address	
Phone Number	

Funding Details			
Funding Type *(Please tick one, Sessions with an AHA are not eligible for a Medicare rebate)*	**NDIS** ☐ **Private** ☐		
NDIS Number ***(if applicable)***		**How are the NDIS Funds managed?**	
		Plan Manager Name ***(if applicable)***	
Has the NDIS Plan or screenshot of goals and allocated funding been attached with referral form?			

Provision: Services Sought (Pick one, both or skip if unsure)			
☐ Assessment *(Assessing what is currently occurring for the client regarding the areas of concern)*		☐ Intervention (*Implementing strategies with the client to address areas of concern)*	
Type of Assessment ***(if known)***		**Preferred Session Frequency** *(Please tick one)*	**Monthly** ☐ **Fortnightly** ☐ **Weekly** ☐
Type of Report ***(if required)***		**Other Frequency**	
Preferred day/s of the week: (Mon-Sat)		**Preferred time slot/s:** (9-5:30pm)	

Reason for Referral/Summary of Concerns: *(Please provide as much detail as possible, and refer to the goals outlined in the inclusion criteria)*

Are there further concerns with participation within any of the below activities				
☐ Support with your child's communication skills including play, speech, language, literacy and social communication. (If yes, contact us on 8418 8544 for a speech pathology referral)				
☐ Dressing	☐ Sleep	☐ Toileting	☐ Leisure	☐ Accessing home and/or community
☐ Self-care and personal hygiene	☐ Mealtimes	☐ Household Tasks	☐ Education	☐ Assistive Technology

Are there any family court orders in place?

☐ Yes ☐ No

Child lives with:

☐ Both parents in one home
☐ Both parents in 2 separate homes. If so, what is the percentage split?
Other? Please describe:

Referrer Details

Referral Source *(internal or external referral)*		**Referral Date**	
Name			
Agency/Organisation			
Email			
Contact Number			

Any additional comments

How did you hear about De Silva Kids Clinic?
(Word of Mouth, Support Co-ordinator, Google, Social Media, GP, Allied Health Practitioner)

☐Word of Mouth ☐Google ☐Social Media ☐Our website ☐GP
☐Other Allied Health Practitioner ☐Support Co-ordinator
☐Other:

FOR OFFICE USE ONLY			
Date Received		**Processed**	
Contacted		**Service Agreement Sent**	