Ability Centre Early Intervention Application/Referral Form

(Formerly known as The Centre for Cerebral Palsy)

Disability Professional Services include:

- Occupational Therapy
- Physiotherapy
- Speech Pathology
- Psychology
- Social Work

Other services offered include:

- Respite for children

This form is for those seeking specialist disability services for babies to children, including those attending school up to and including Pre-primary level.

For more information on the range of services available please refer to:

Ability Centre website: www.abilitycentre.com.au

Ability Centre email: therapy@abilitycentre.com.au

Disability Services Commission website: www.disability.wa.gov.au

Section 1 | Information about Referring

Part 1: Eligibility
To be eligible for specialist disability services a person must:

a) Have a disability as defined by the Disability Services Act 1993
The Disability Services Act (1993) defines disability as a condition that:

- Is attributable to an intellectual, cognitive, neurological, sensory or physical impairment or a combination of those impairments;
- Is permanent or likely to be permanent;
- May or may not be episodic in nature;

and results in:

- A substantially reduced capacity of the person for communication, social interaction learning or mobility; and
- A need for continuing support services.

AND

b) Be legally entitled to permanently reside in Australia and permanently reside in Western Australia.

Part 2: Service Access
To access specialist disability services, a person must meet eligibility criteria AND the Ability Centre's service access criteria. **Fee for service is also available for individuals not eligible, please contact the Ability Centre for more details.**

Section 2 | Details of Individual Being Referred

Child's Contact Details

Preferred Name: _____

Given Name: _____

Surname: _____

Male / Female (Please Circle) Date of Birth: _____

Country of Birth: _____

Australian Permanent Residency Status

- ☐ Australian Citizen
- ☐ Australian Permanent Resident
- ☐ New Zealand Citizen
- ☐ Other (Please Specify) _____

Address

Home Address: _____

Suburb: _____ Post Code: _____

Medicare No: _____

Centrelink No: _____

Health Care Card No: _____

What is the **MAIN** language spoken in your home? _____

Do you require Interpreter services?

- ☐ No
- ☐ Yes - for non-spoken communication
- ☐ Yes - for spoken language other than English

What is your most effective form of communication?

- ☐ Little or no effective communication
- ☐ Other effective non-spoken communication
- ☐ Sign Language
- ☐ Spoken Language

Are you of ...?

- ☐ Aboriginal but not Torres Strait Islander Origin
- ☐ Both Aboriginal and Torres Strait Islander Origin
- ☐ Torres Strait Islander but not Aboriginal Origin
- ☐ Neither Aboriginal origin nor Torres Strait Islander Origin

Who do you live with:

- ☐ Live with family
- ☐ Live with others (please specify) _____

Residential Setting:

- ☐ Private Residence
- ☐ Residence within an Aboriginal/Torres Strait Islander community
- ☐ Short term crisis accommodation or transitional accommodation
- ☐ Other (please specify) _____

Section 3 | Compensation

Are you applying for compensation? ☐Yes ☐No

Are you currently receiving compensation? ☐Yes ☐No

If **yes** to either of the above, please provide details:

Insurance Agency: (e.g. ICWA) _____

Claim Number: _____

_____

Claim Manager: _____ Contact no: _____

Postal or email address: _____

_____

Solicitor's Agency: _____

Solicitor's Name: _____ Contact no: _____

Postal or email address: _____

_____

Section 4 | Parent / Carer / Legal Guardian Details

Please advise if there are any **specific custody or access provisions** you wish us to be made aware of:

_____

_____

Primary Contact

Given Name: _____

Preferred Name: _____ Surname: _____

Relationship to Person being referred: _____

Date of Birth:_____

Home Address: _____

_____ Post Code: _____

Phone Number:
(Home/Work/Mobile) _____

Email Address: _____

Spoken Language: _____ Interpreter Required: ☐Yes ☐No

Best Time and Day to Contact. _____

Alternative Contact (optional)

Given Name: _____

Preferred Name: _____ Surname: _____

Relationship to Person being referred: _____

Home Address: _____

_____ Post Code: _____

Phone Number:
(Home/Work/Mobile) _____

Email Address: _____

Spoken Language: _____ Interpreter Required: ☐Yes ☐No

Section 5 | Disability

What is the child's primary/ main disability? – **Please tick (√) one box only**

- ☐ Acquired Brain Injury
- ☐ Autism Spectrum Disorder
- ☐ Intellectual / Global Developmental Delay
- ☐ Down Syndrome
- ☐ Multiple Sclerosis
- ☐ Cerebral Palsy
- ☐ Motor Neurone Disease
- ☐ Muscular Dystrophy
- ☐ Para/quadri(tetra)/hemiplegia
- ☐ Spina Bifida
- ☐ Psychiatric Disability_____
- ☐ Deaf blind - dual sensory
- ☐ Other (please specify)_____

Do they have any other disability? – Please tick (√) as many as applicable

- ☐ Acquired Brain Injury
- ☐ Specific Learning - other than Intellectual _____
- ☐ Attention Deficit (hyperactivity) Disorder
- ☐ Autism Spectrum Disorder
- ☐ Intellectual / Global Developmental Delay
- ☐ Down Syndrome
- ☐ Multiple Sclerosis
- ☐ Cerebral Palsy
- ☐ Motor Neurone Disease
- ☐ Muscular Dystrophy
- ☐ Para/quadri(tetra)/hemiplegia
- ☐ Spina Bifida
- ☐ Epilepsy
- ☐ Psychiatric Disability_____
- ☐ Deaf blind - dual sensory
- ☐ Vision_____
- ☐ Hearing_____
- ☐ Speech Impairment_____
- ☐ Other (please specify)_____

Any supporting documentation you wish to provide may assist us to make a faster assessment of this application.

Section 6 | Health and Behaviour

Has the child had, or going to have, surgery or specialist medical attention:

- ☐ No
- ☐ Yes (Please Specify) _____

For the child, are any of the following issues present?

- ☐ Aspiration (gagging, choking or recurrent chest infections)
- ☐ Difficulty swallowing during mealtimes
- ☐ Tracheostomy
- ☐ Suctioning and/or oxygen therapy
- ☐ Urinary catheter or stoma
- ☐ Pressure sores
- ☐ Significant pain or discomfort
- ☐ Self-injurious behaviour or behaviour that puts other people at risk
- ☐ Excessive weight gain or loss
- ☐ Anxiety or other Mental Health concern
- ☐ Recurrent Falls

Does the child have any other health concerns (Please specify)

_____

_____

_____

_____

_____

_____

_____

_____

Any supporting documentation you wish to provide may assist us to make a faster assessment of this application.

Section 7 | Help and Supervision

Please indicate the level of help or supervision required in each life area. (rows a-g)

Tick only one level of help or supervision (columns 1-4)

Any supporting documentation you wish to provide may assist us to make a faster assessment of this application.

	1. Unable to do or always needs help/ supervision	2. Sometimes needs help/ supervision	3. Does not need help but uses aids /equipment	4. Does not need help and does not use aids/ equipment
a) Self Care: • Washing • Dressing • Eating • Toileting	☐	☐	☐	☐
	Please describe help/equipment needed:			
b) Mobility • Moving around home • Getting in/out of a bed or a chair • Transport - private and/or public	☐	☐	☐	☐
	Please describe help/equipment needed:			
c) Communication: • Making self-understood • Understanding others	☐	☐	☐	☐
	Please describe help/equipment needed:			
d) Interpersonal Relationships: • Making and keeping friends • Behaving in acceptable ways • Coping with feelings	☐	☐	☐	☐
	Please describe help/equipment needed:			

Section 7 | Help and Supervision (continued)

Answer the following questions e) to g) only if the child is 5 years old or over.

	1. Unable to do or always needs help/ supervision	2. Sometimes needs help/ supervision	3. Does not need help but uses aids /equipment	4. Does not need help and does not use aids/ equipment
e) Learning: • Understanding new ideas • Remembering • Problem solving • Decision making • Paying attention • Undertaking single or multiple tasks • Carrying out daily routine	☐	☐	☐	☐
	Please describe help/equipment needed:			
f) Education: • Actions, behaviours and tasks an individual performs in an education setting, e.g. College.	☐	☐	☐	☐
	Please describe help/equipment needed:			
g) Community Participation: • Recreation and leisure • Religion and spirituality • Human rights • Political life and citizenship • Economic life, such as handling money	☐	☐	☐	☐
	Please describe help/equipment needed:			

Section 8 | Consent for Referral

Collection:

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 _____ DOB _____

Parent / Legal Guardian's Name (if applicable) _____

Use of Information:

I/We give consent to Ability Centre to access reports and information regarding _____ (child's name) to assess if he/she is eligible to receive services:

- ☐ Medical Reports _____
- ☐ Therapy Reports _____
- ☐ Educational Reports _____
- ☐ Psychological Reports _____
- ☐ Other _____

Third party disclosure:

If you have consented to us contacting other parties, please provide their contact details below:

Existing Therapy Provider

Organisation: _____

Contact details: _____

Local Area Coordinator/ My Way Coordinator

Name: _____

Contact details: _____

General Practitioner

Doctor: _____

Practice: _____

Contact: _____

Specialist

Name: _____

Contact: _____

School/Day Care

Name of school: _____
Suburb: _____
Class Level/ Year: _____
Teacher's name: _____
Contact details: _____

Princess Margaret Hospital

Name: _____

Contact details: _____

Department for Child Protection:

Name: _____

Contact details: _____

Other

Organisation: _____

Contact details: _____

Signed: _____

Name: _____

Relationship to Person being Referred: _____

Date: _____

Section 9 | Checklist

Please complete this checklist to assist us to make a faster assessment of this application

The following sections have been completed:

- ☐ Child's Contact Details
- ☐ Compensation Details (if applicable)
- ☐ Parent / Carer / Legal Guardian Contact Details
- ☐ Disability
- ☐ Health and Behaviour
- ☐ Help and Supervision
- ☐ Consent for Eligibility Screening
- ☐ Other Supporting Agencies Contact Details
- ☐ Checklist and Supporting Documentation

Required supporting documentation attached:

- ☐ Evidence of Australian Permanent Residency (such as Australian Birth Certificate, Passport or Visa)
- ☐ Evidence of permanently residing in Western Australia (such as a phone bill, electricity bill e.t.c)
- ☐ Evidence of Diagnosis (such as report from General Practitioner or Specialist stating diagnosis)
- ☐ Evidence of Health and Behaviour (optional)
- ☐ Evidence of Help and Supervision (optional)

Privacy Disclaimer:
Please note that the Ability Centre is required to release information about service users to the Disability Services Commission and then without identifying you, to the Australian Institute of Health and Welfare (AIHW), to enable statistics about disability services and their clients to be compiled.

The information will be kept confidential. This information is used for statistical purposes only and will not be used to affect your entitlements or your access to services. As a user of National Disability Agreement (NDA)-funded services you have the right to access your own files and to update or correct information included in the Annual Client and Service Data Collection (ACDC) collection.

Service Providers obligations under the *Privacy Act 1988*
All Disability Professional Service Providers are bound by the *Privacy Act 1988*. As such, all providers undertake to adhere to the National Privacy Principles which appear in Schedule 3 of the Privacy Act; which regulate how we may collect, use, disclose and store personal information and how individuals may access and correct personal information held about them. For further information please refer to www.privacy.gov.au or www.comlaw.gov.au

Please return this form to:

The Intake Officer
PO Box 61
MT LAWLEY WA 6929

OR

The Ability Centre's email: therapy@abilitycentre.com.au