Confidential Patient Information

Request for Services

OT | PSYCH | SPEECH THERAPY | Other

Adelaide Paediatrics

About Your Child

First name(s): _____ Preferred Name: _____

Surname: _____ Date of Birth: _____

Gender: (Please circle) Male / Female / Preferred _____

Address: _____

Medicare no. _____ Reference no. on card _____

NDIS ☐ Mental Health Care Plan/FPS ☐ Enhanced Primary Care Plan ☐ Other ☐ _____

Current Diagnosis (if any) _____

Is your child currently or had past Allied Health support/therapy: _____

_____

Your Appointment

PYSCHOLOGY ☐ OCCUPATIONAL THERAPY ☐ SPEECH THERAPY ☐

***Preferred* Day & Time:** Mon ☐ _____ Tues ☐ _____ Wed ☐ _____ Thurs ☐ _____ Fri ☐ _____

***Preferred* Location:** Mile End ☐ Kensington Park ☐ Elizabeth Vale ☐ Bedford Park ☐

Mount Barker ☐ Morphett Vale ☐ Wayville ☐

Presenting Area of Concern (tick the boxes that apply)

Anxiety ☐ Behaviour Support ☐ Emotional Regulation ☐ Low Mood ☐ School Refusal ☐

Trauma ☐ Social Skills ☐ Toileting ☐ Co-ordination/Fine Motor ☐ Speech ☐ Auditory Processing ☐

Phonological Awareness ☐ Difficulty Sleeping ☐ Feeding Difficulty ☐ Other .....

Parent / Caregiver Information *(for best daytime contact)*

First name(s): _____ Surname: _____

Relationship to child: _____ Email: _____

Address: _____ Suburb: _____

Best Contact Telephone: (W) _____ (H) _____ (M) _____

Acknowledgement & Consent

☐ **I agree to notify Adelaide Paediatrics to remove my child from the 'Request for Service' wait list if my child commences therapy elsewhere and/or services are no longer required.**

☐ **I will notify Adelaide Paediatrics of any change of contact details.**

☐ **I understand my child will be removed from the 'Request for Service' wait list if I fail to respond to two or more attempts to contact me via phone or email.**

Name: _____ **Signature:** _____

Date: ..... / ..... / .....