Canterbury
District Health Board
Te Poari Hauora ō Waitaha

Child Development Service, Montreal House
440 Montreal Street, Christchurch 8013
phone: (03) 383 6820
facsimile: (03) 03 377 3242
email: referralschilddevelopment@cdhb.health.nz

Request for Support – Therapy Team
Child Development Service

Whakapiki Hauora o te Tamaiti me te Whānau
To improve, promote and support the health of the child and whānau

PLEASE TICK SERVICES REQUIRED:

☐ Occupational Therapy ☐ Physiotherapy ☐ Speech-language Therapy ☐ Dietitian ☐ Social Work

☐ Housing ☐ Equipment ☐ Wheelchair / Seating ☐ Kaitautoko / Whānau Support

CHILD AND FAMILY/WHĀNAU INFORMATION			
Child's name:	**NHI:**	**DOB:**	**Ethnicity:**
Address/s:			
Phone numbers: Home:	Mobile:		
Email address:			
Parent/Caregiver's names:			
Is the family/whānau/caregiver aware of the referral? ☐ Yes ☐ No Reason for no:			
Contact referrer first? ☐ Yes ☐ No			
Will an interpreter be required? ☐ Yes ☐ No **Language spoken at home:**			

CONCERNS AND PRIORITIES	
FORMS WITH INSUFFICIENT INFORMATION WILL BE RETURNED	
What are the concerns and/or priorities of the family/whānau/caregiver?	
What specifically are the family/whānau/caregivers requesting support with?	

DIAGNOSIS AND CLINICAL INFORMATION	
Diagnosis/Disability **Clinical Information**	*Please attach any reports or further information that will assist with triage.*

REQUEST FOR SUPPORT - THERAPY TEAM

C110026

ADDITIONAL INFORMATION			
GP:			
Lifelinks:	☐ Yes ☐ No ☐ Unsure		
Other professionals:	*e.g. Paediatrician, Orthopaedic consultant, Orthopaedic coordinator, Neurologist, Children's Outreach Nurse, Palliative Care CNS, Child Development CNS, Child Development Coordinator, ASD coordinator, Explore behaviour, Plunket, Early Start, Right Service Right Time, Ministry of Education*		
Preschool/School:		**ORS funded:** ☐ Yes ☐ No ☐ Unsure **High Health Funded:** ☐ Yes ☐ No ☐ Unsure	
Ministry of Education professionals:	*e.g. Early Intervention Teacher, SLT, Psychologist, Kaitakawaenga, PT, Occ Th,*		
Referrals made to others:			
REFERRED BY			
Name:		**Title:**	**Date:**
Contacts:	Phone:	Email:	