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

Request for Support – Therapy Team
Child Development Service

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

Please tick relevant services required. **Forms with insufficient information will be returned**

☐ Occupational Therapy ☐ Physiotherapy ☐ Social Work ☐ Wheelchair/Seating
☐ Housing/equipment

CHILD AND FAMILY/WHĀNAU INFORMATION			
Child's name:		**NHI:**	**DOB:**
Address:		**Email:**	
Phone numbers:	Home:	Mobile:	
Parent's/Caregiver's names:			
Is the family/whanau aware of the referral? ☐ Yes ☐ No		**Contact referrer first?** ☐ Yes ☐ No	
Will an interpreter be required? ☐ Yes ☐ No		**Language spoken at home:**	
What are the families/whanau/ carers priorities/ concerns? ***(What specifically would the family/ whanau like OT/PT or SW to help with?)***			
Diagnosis/ Clinical Information			

Report attached ☐

Please tick the functional difficulties the child is having in the following areas and ***describe further***.

PHYSICAL SKILLS		
☐ Developmental milestones	☐ Gross motor skills	☐ Fine motor skills
☐ Altered muscle tone	☐ Transfers	☐ Mobility
☐ Trips/falls/clumsiness	☐ Tires easily/fatigue	☐ Wheelchair/seating/sleep
☐ Walking/standing equipment		

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DAILY LIVING SKILLS

☐ Washing/grooming ☐ Dressing ☐ Mealtimes
☐ Sleep ☐ Toileting ☐ Play
☐ Organisation/planning ☐ Routines ☐ Bathing/shower/toileting equipment
☐ Behaviour

ENVIRONMENTAL AND SOCIAL CIRCUMSTANCES

☐ Home environment/housing ☐ Transport ☐ Safety
☐ Care and protection concerns ☐ Family life compromised ☐ Financial/benefit advice
☐ Community resources

OTHER

☐ Post-botox/orthopaedic surgery ☐ Post-medical admission ☐ Discharge summary attached
☐ School transition

GP:

Medical and other professionals:
(eg. paediatrician, orthopaedic consultant, neurologist, PT, OT, SLT, Dietitian, SW, EIT, psychologist, behaviour specialist, Early Start, Plunket)

Preschool/School: Phone:

ORS: ☐ Yes ☐ No | **High Health Funding:** ☐ Yes ☐ No | **Physical Disability Team:** ☐ Yes ☐ No

Referrals made to others:

REFERRED BY

Name:	**Title:**	**Date:**
Contacts: Phone:	Email:	
GP:		