BAYNAV 1001 9/23

Te Whatu Ora
Health New Zealand
Hauora a Toi Bay of Plenty

REQUEST FOR SUPPORT
CHILD DEVELOPMENT SERVICE, WESTERN BOP

Forms with insufficient information will be returned

Date of Referral: _____

CHILD AND FAMILY/WHĀNAU INFORMATION	
Child's name:	NHI number:
Date of birth:	Gender: ☐ Male ☐ Female
Carer name(s)	Email:
Address:	Ethnicity/Iwi:
Telephone number(s):	
Consent from family/whānau given for referral? ☐ Y ☐ N	Will an interpreter be required? ☐ Y ☐ N Language spoken at home:

SERVICE REQUESTED (Please provide details on page 2 to support request)	
☐ **VNT** (under 2.5 years)	☐ Gross Motor ☐ Sensory Issues ☐ Fine motor/play ☐ State Awareness/ Regulation issues ☐ ADLs (e.g. bathing, eating)
☐ **Occupational Therapy**	☐ ADLs ☐ Sensory needs ☐ Fine motor/play ☐ Equipment needs ☐ Home adaptation ☐ Safety issue
☐ **Physiotherapy**	☐ Gross motor concerns/ delay ☐ Neuromuscular needs ☐ Equipment needs
☐ **Speech & Language Therapy** **Under 2 years of age:** Communication and swallowing issues **Over 2 years of age:** Only seen for swallowing issues if already with Ministry of Education SLT	☐ Speech and language concerns/delays ☐ Delayed oromotor skills ☐ Frequent coughing/choking during intake ☐ Recurrent respiratory symptoms (possible aspiration pneumonia) ☐ Nil by mouth ☐ Tube fed ☐ Aversion/refusal to feeding
☐ **Dietitian** Weight percentile: _____ Length/height percentile: _____ Head circumference percentile: _____ BMI percentile (age 2 and older):____ Date last measured: _____	☐ Faltering growth **growth measurements are required for referral acceptance* ☐ Tube-feeding ☐ Nutritional deficiencies (please specify:_____) ☐ Other: _____
☐ **Psychology**	☐ Autism Spectrum Disorder (ASD) assessment and formulation over 7 years: please provide details to support referral, e.g. SRS forms (under 7 years please refer to ASD co-ordinator for MDAT) ☐ Cognitive/Intellectual assessment and formulation (incl. evidence of delay, e.g. KBIT-2 assessment, results of school assessment)
☐ **Social Worker**	Please provide details on page 2
☐ **ASD Incredible Years**	Programme for parents

BAYNAV 1001 4/21

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WHAT ARE THE FAMILIES/WHĀNAU/CARERS PRIORITIES/CONCERNS?
(What specifically would the family/whānau like support with?)

DIAGNOSIS/CLINICAL INFORMATION

REFERRER DETAILS

Full name: _____ Designation: _____

Phone _____ Email: _____

Agency and postal address: _____

OTHER AGENCIES INVOLVED (e.g. Paediatrician, Seating to Go, Family Start)

GP:

Preschool/School: Ph:

ORS: ☐ Y ☐ N	Physical Disability Team: ☐ Y ☐ N	High Health Funding: ☐ Y ☐ N

Carer is aware that Child Development Service may obtain information from other agencies. ☐ Y ☐ N

PRINT SUBMIT FORM TO CDS CLEAR FORM