

Music Therapy Referral Form

Name:	First names Surname	Please circle one M / F	Date of Birth:
Diagnosis:			
Ethnicity:			

Name of parents/caregivers:	
Postal address:	Postcode:
Contact details:	
Home:	Work:
Mobile:	Email:

Sibling's Names	DOB	Genogram <i>(for office use)</i>

Name of School:		
Address:		
Postcode:		
Name of contact:	Position:	Tel:
<i>(for office use)</i>		
Permission to contact? Yes <input type="checkbox"/> No <input type="checkbox"/>		Latest IEP Received? Yes <input type="checkbox"/>

Other professionals	Service	Contact details
<i>Speech Language Therapist</i> Name:		Tel: Email: Report: Yes <input type="checkbox"/>
<i>Physiotherapist</i> Name:		Tel: Email: Report: Yes <input type="checkbox"/>
<i>Occupational therapist</i> Name:		Tel: Email: Report: Yes <input type="checkbox"/>
<i>Paediatrician</i> Name:		Tel: Email: Report: Yes <input type="checkbox"/>
Other: Name & contact details:		Medication? Yes <input type="checkbox"/> No <input type="checkbox"/> Details: PTO
Report: Yes <input type="checkbox"/>		
Previous music therapy? Yes <input type="checkbox"/> No <input type="checkbox"/> Details:		

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First names Name:	Surname	Please circle one M / F	Date of Birth:
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Reason for referral:

Hopes and expectations:

Conditions that the music therapist needs to be aware of: (epilepsy, challenging behaviour, etc..)

Means of communication: (Speech, Makaton, etc..)

Languages spoken at home:

Any relevant strengths or difficulties:

Referred by: _____ Date: _____

Relationship to child/young person: _____ Signed: _____

Where did you hear about RMTTC? _____

Please return this form to RMTTC, 15 Surrey Crescent, Grey Lynn, Auckland 1021

CHECK LIST (for office use)

- Session type
- Cost of therapy discussed
- Policies on confidentiality and safety
- Parent and carers guide given