



Music Therapy Referral Form

Name of child:	M / F	Date of Birth:
Diagnosis/condition:		

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

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

Name of School:		
Address:		
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"/>	

Paraprofessionals	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"/>
<i>Other:</i> Name & contact details:	Medication? Yes <input type="checkbox"/> No <input type="checkbox"/>	Details:
Report: Yes <input type="checkbox"/>		PTO

Reason for referral:
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Parents hopes and expectations:
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Conditions that the music therapist needs to be aware of: (epilepsy, challenging behaviour, etc..)
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Means of communication: (Speech, makaton, etc..)
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Languages spoken at home:
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Any relevant strengths or difficulties:
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Referred by: _____ Date: _____

Relationship to child: _____ Signed: _____

Please return this form to 23 Dacre St, Eden Terrace, Auckland 1010

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CHECK LIST (for office use)

- Session type
- Fees discussed: (including Carer Support, ACC, subsidy)
- Policies on confidentiality and safety
- Parent and carers guide given