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Kids First Physiotherapy

Mobile Paediatric Physiotherapy and Case Management

Referral Form

Name: _____

Date of birth: _____ **Date of referral**: _____

CRN (if Better Start Funding): _____

Parent / Carer / Primary contact (listed as 1. as per court order, if applicable)

1 _____ 2 _____

Address (as per Centrelink, if applicable): _____

_____

Contact details: (H): _____ (M) _____ (W) _____

Email: _____

Parent/guardian acknowledged the fee schedule: Yes ☐ No ☐

Funding options (please tick if applicable):

Better Start Funding ☐ Private Health Insurance ☐

Medicare (EPC/CDM) ☐ Other insurance eg.CTP ☐

Main concern(s) requiring physiotherapy (brief outline) : _____

_____

Diagnosis (if applicable): _____

Additional information (if known):

General practioner / Paediatrician: _____

Other Specialists involved: _____

Allied Health Professionals involved: _____

_____

_____

Medical Information (please leave blank if unsure, enter 'No' if known, enter details if 'Yes'):

Medical condition(s) eg. allergies, epilepsy: _____

Visual impairment: _____ Hearing impairment: _____

Implants/devices eg insulin pump, cochlear implant, hearing aid): _____

Privacy Statement

Personal and medical information about your child is collected with consent for the purpose of providing appropriate and effective treatment. This practice has a Privacy Policy Statement on the collection, use, disclosure and security of information collected. Information gathered will not be disseminated in any way without specific consent for this purpose.

_____ **Date**: _____

Parent/Guardian