Application for the Paediatric Developmental Program

Introduction

Thank you for taking time to complete this application. The form will be used to gather information to help with understanding your child's situation.

Please answer as many of the questions as you can and provide as much detail as possible. There are some questions you can skip if you don't know the answer or it the question is not relevant.

Throughout the form there will be opportunities to mention and attach relevant letters or reports.

If you require help with completing this form, please ring Royal Far West on 02 8966 8500 and ask to speak to the Intake Office.

Reason for Application

Who recommended your child come to Royal Far West and why?

_____

_____

_____

Who is the referring doctor?

_____

What are the main concerns about your child?

1. _____
2. _____
3. _____

In what way do you hope that Royal Far West could make a difference?

_____

_____

_____

What are your priorities or goals for your child?

1. _____
2. _____
3. _____

Has your child ever received services from Royal Far West? ▫ Yes ▫ No

Royal Far West
Children's health, country-wide

Child and Family Details

Child Information

Child's first and middle name: _____

Child's last name: _____

Gender: ▫ Male ▫ Female ▫ X (Indeterminate/Intersex/Unspecified)

Date of birth: _____/ _____/ _____ Age: _____

Country of birth: _____

Residential Address: _____

Town: _____ Postcode: _____

Phone (h): _____ (m): _____

Child's Medicare number: _____

Child's position on card: _____ expiry date: _____

Health Care Card: ▫ Yes ▫No Number: _____

Does your child have an NDIS package? ▫ Yes ▫ No

Parent / Carer 1:

Full Name: _____ Relationship to child: _____

Phone (h): _____ (m): _____ (w): _____

Email address: _____

Date of birth: _____/ _____/ _____ Age: _____

Occupation: _____ ▫Full-time ▫Part-time ▫Casual

Parent / Carer 2:

Full Name: _____Relationship to child: _____

Phone (h): _____ (m): _____ (w): _____

Email address: _____

Date of birth: _____/ _____/ _____ Age: _____

Occupation: _____ ▫Full-time ▫Part-time ▫Casual

Main contact person for child:

- ▫ Parent/Carer 1
- ▫ Parent/Carer 2
- ▫ Other

If Other, Name: _____ Relationship to child: _____
Phone (h): _____ (m): _____ (w): _____
Email address: _____

What is the best way for Royal Far West to make contact? (you can select more than one)

- ▫ Phone call
- ▫ Voice message
- ▫Email
- ▫SMS

Living arrangement:

- ▫ 2 Natural Parents
- ▫ Mother Alone
- ▫ Mother and Other
- ▫ Other _____
- ▫ Father Alone
- ▫ Father and Other
- ▫ Foster Family
- ▫ Relatives
- ▫ Adoptive Parents

Comments _____

Are you the legal guardian of this child? ▫ Yes ▫ No
Do you share this guardianship with another parent? ▫ Yes ▫ No
If you are not the legal guardian, who is the legal guardian of this child?
_____

Are there any care arrangements or court orders in place that would be important for us to know about? e.g. Child protection order/ Children's Court order, Family Court order, or AVO ▫ Yes ▫ No
If Yes, please describe _____
_____

Please attach copies of any court orders (parental responsibility orders).

Siblings:

Name of sibling	DOB	Living at home Yes/No	Needs

Child and Family Details (continued)

Culture and language

Is your child of Aboriginal and / or Torres Strait Islander origin? (please tick below)

- ▫ No
- ▫ Yes, Aboriginal
- ▫ Yes, Torres Strait Islander
- ▫ Both Aboriginal and Torres Strait Islander
- ▫ Other
- ▫ Decline to comment

What nationality / culture is your child part of? _____

Does your child speak a language other than English? ▫Yes ▫No

If Yes, Which language(s)? _____

What is the main language spoken at home? _____

Do you or your child require an interpreter? ▫ Yes ▫ No

If Yes, which language(s)? _____

Does your child take part in cultural or religious practices that are important to your family? For example: going to church, mosque or temple, other religious or spiritual observances, or visits to Aboriginal significant places?

▫Yes ▫No If Yes Detail _____

Housing

Where does your child live? ▫Unit ▫House ▫Farm ▫Other If Other, details_____

If your child lives out of town, how far do they live from the closest town? _____

Do you feel there is enough space in your home for the needs of your family? ▫ Yes ▫ No

Does anyone else live in the same household? ▫ Yes ▫ No If Yes, details_____

How often do you move? _____

Financial situation

Is your family receiving any financial support? e.g. Centrelink payment, rental assistance

▫ Yes ▫ No If Yes, details_____

Are you currently impacted by the drought? ▫ Yes ▫ No

Are you currently under financial stress? ▫ Yes ▫ No

Technology

Do you have access to the Internet? ▫ Yes ▫ No

Do you have any of the following technology at home:

▫ Computer

▫ Laptop

▫ Mobile phone that can receive e-mails or SMS

▫ Tablet such as iPad

Access

Do you need any help with filling out forms? ▫ Yes ▫ No

Do you have a hearing or sight difficulty? ▫ Yes ▫ No If Yes, details_____

Does anyone in the family need any help with communication? ▫ Yes ▫ No
If Yes, details_____

Does anyone in the family require wheelchair access? ▫ Yes ▫ No

Does anyone in the family have special dietary requirements? ▫ Yes ▫ No
If Yes, details_____

Medical services

Child's local General Practitioner:

Name: _____

Location: _____ Phone: _____

E-mail: _____ Fax: _____

Does your child see a local Paediatrician? ▫ Yes ▫ No

If Yes, please provide the following details:

Name: _____

Location: _____Phone: _____

When did your child last see the Paediatrician? _____

Is there a plan for your child to see the Paediatrician again? ▫ Yes ▫ No

If yes, when is their next appointment due? _____

About Your Child and the Family

Section 1. Learning and Development

Child's interests and strengths

What are your child's interests? What do they like doing?

_____
_____
_____

What are your child's strengths? What do they do well?

_____
_____
_____

Early development - pregnancy, birth, and the early years

Were there any problems or significant stressors during the pregnancy? ▫ Yes ▫ No

If so, what? _____

Was the child born at full term? ▫ Yes ▫ No If not, at how many weeks: _____

Were there any problems during the birth? ▫ Yes ▫ No If Yes, details:_____
_____

Birth weight: _____kg _____g or _____ lb _____ oz

Did your child have any medical problems when they were a baby? ▫ Yes ▫ No

If Yes, Details: _____

Were there any feeding difficulties? ▫ Yes ▫ No If Yes, Details:
_____

Has your child had any difficulties with chewing, swallowing or fussy eating?

▫ Yes ▫ No If Yes, Details: _____

Do you have any concerns regarding your child meeting developmental milestones, for example: sitting, crawling, walking, speaking, toilet training? ▫ Yes ▫ No

Please complete the table below about your child's development:

Milestone	Age	Comments
Sitting		
Crawling		
Walking		
Saying first word		
Toilet training		

Communication

Do you have any concerns about your child's speech or communication? ▫ Yes ▫ No

Does your child have any difficulties with the following?

Communication difficulties	Yes	Comments
Speech sounds or pronouncing words		
Following directions, answering questions or understanding what you say to them		
Putting words into a sentence or telling a story		
Stuttering		
Voice quality		
Changes in speech sounds or way of talking in some situations e.g. baby sounds, change of voice		

Has your child seen a Speech Pathologist? ▫ Yes ▫ No

If Yes, Details: _____

Speech Pathologist name:_____ location:_____

Date of first appointment:_____

Is your child still seeing the Speech Pathologist: ▫ Yes ▫ No

How often? _____

Please attach any reports if available

General skills

Does your child have difficulty with the following skills?

General Skill	Yes	Comments
Handwriting		
Fine motor skills e.g. using scissors, pencils		
Visual perception e.g. losing their place when reading, difficulty copying or difficulty with puzzles		
Balance and coordination e.g. Does your child appear clumsy?		
Self-care e.g. dressing, using cutlery		
Gross motor skills e.g. running and jumping		
Using the toilet appropriately		
Sensory difficulties e.g. unusual responses to sound/touch/movement/heights		

Has your child seen an Occupational Therapist? ▫ Yes ▫ No

If Yes, please complete the following details:

Occupational Therapist name:_____ location:_____

Date of first appointment:_____

Is your child still seeing the Occupational Therapist: ▫ Yes ▫ No How Often?_____

Please attach any reports if available.

Education and learning

Name of Daycare / Preschool / School: _____

Location: _____

Year: _____

Name of class teacher or daycare / preschool director: _____

Name of school counsellor (if involved): _____

Are you concerned about your child's learning? ▫ Yes ▫ No

If Yes, Details_____

_____

Are you concerned about your child's behaviour at school? ▫ Yes ▫ No

If Yes, Details_____

_____

Does your child have any difficulties with playing or working with other students? ▫ Yes ▫ No

If Yes, Details_____

_____

Are you aware if your child's teacher has concerns? ▫ Yes ▫ No

If Yes, Details_____

_____

Does your child receive any extra support from the teacher or a teacher aide? ▫ Yes ▫ No

Please provide below any further information regarding your child's education / learning history that you think would be useful for us to know. You can also attach any relevant reports that you think will be helpful.

_____

_____

_____

Section 2. Health and medical history

How would you describe your child's health?

_____

_____

Does your child have any diagnosed conditions (such as cerebral palsy, autism, ADHD, or other medical or health condition)? ▫ Yes ▫ No

If Yes, Details:

_____

_____

Does your child have any of the following conditions?

Condition	Yes / No	Details	Management Plan Yes / No
Asthma			
Allergies			
Seizures or epilepsy			
Diabetes			

Please attach any management or safety plans.

Does your child take any medication? ▫ Yes ▫ No

If yes, please provide name of current medication, dose and the reason for taking it

_____

_____

_____

Are your child's immunisations up to date? ▫ Yes ▫ No

Has your child ever had a blood test? ▫ Yes ▫ No

If Yes, Details: _____

Sleep

Does your child have any sleep problems? ▫ Yes ▫ No

Does your child have difficulties falling or staying asleep? ▫ Yes ▫ No

Details: _____

Is your child often tired or low on energy? ▫ Yes ▫ No

Details: _____

Eating

Do you have any concerns about your child's eating? ▫ Yes ▫ No

Details: _____

Is your child fussy about what food they will eat? ▫ Yes ▫ No

Details: _____

Does your child need a special diet? ▫ Yes ▫ No

Details: _____

Do you worry about your child being under or over weight? ▫ Yes ▫ No

Details: _____

Does your child have difficulties with constipation? ▫ Yes ▫ No

Has your child ever seen a dietitian? ▫ Yes ▫ No

Hearing

Are you concerned about your child's hearing? ▫ Yes ▫ No

Has your child had their hearing tested? ▫ Yes ▫ No
If yes, where, when and what were the results?

_____

_____

Vision

Are you concerned about your child's sight? ▫ Yes ▫ No

Does your child wear glasses? ▫ Yes ▫ No

Does your child complain about headaches, blurred vision or sore eyes? Do they often squint or rub their eyes? ▫ Yes ▫ No Details: _____

_____

Has your child had their eyes tested? ▫ Yes ▫ No If yes, where, when and what were the results?

_____

_____

Oral health

Does your child have a local dentist? ▫ Yes ▫ No

If Yes, please provide the following details:

Name: _____ Location: _____
Phone: _____

When did your child last see the dentist?_____

Medical History

Please provide below any further information regarding your child's or family's medical history that you think would be useful for us to know.

Child:_____

_____

_____

Family:_____

_____

_____

Please attach any reports or test results that you think will be helpful.

Section 3. Emotional wellbeing, behavior and mental health

Do you have any concerns about your child's behaviour, emotional wellbeing or mood?

▫ Yes ▫ No Details: _____

_____

Does your child have difficulty expressing their emotions and letting you know how they are feeling?

▫ Yes ▫ No Details: _____

Does your child struggle to pay attention? For example, very active, hard to sit still, has trouble staying focused, daydreams a lot

▫ Yes ▫ No Details: _____

Does your child show verbal or physical aggression towards family members or other children?

▫ Yes ▫ No Details: _____

Does your child show unsafe behaviour e.g. running away, not following safety instructions?

▫ Yes ▫ No Details: _____

Do you have any concerns about your child's use of technology, the internet or social media?

▫ Yes ▫ No Details: _____

Does your child have any difficulties making and / or keeping friends?

▫ Yes ▫ No Details: _____

Does your child often worry or seem anxious?

▫ Yes ▫ No Details: _____

Has your child had any help for mental health issues in the past?

▫ Yes ▫ No Details: _____

Is there a family history of mental health, developmental, behavioural or learning concerns, or disabilities? For example, intellectual disability, Autism Spectrum Disorder, depression, anxiety, other mental health issues

▫ Yes ▫ No Details:

_____

_____

_____

_____

Section 4: Support and services involved

Support within the family and community

Do you have extended family support close by?

▫ Yes ▫ No Details: _____

Are there any other adults involved in caring for your child or who are significant to your child?

▫ Yes ▫ No Details: _____

Do you as parents/ carers have other caring responsibilities? For example, caring for a baby or children under school age, caring for someone with a disability or illness, or caring for an older person.

▫ Yes ▫ No Details: _____

Local professional and community support

Are there any services involved in supporting your child or the family? For example, allied health, family support, before and after school care, casework services, local community organisations?

▫ Yes ▫ No

Please provide details in the table below:

Profession and Service	Name of Worker	How often is the service provided?	When did this service or activity start?	Contact details
Example: *Psychologist* *Community Health Centre*	*Jane Smith*	*Fortnightly*	*Started June 2018 and finished Dec 2018*	*Town* *Phone number*

Section 5. Family Situation

Have there been any significant events or recent changes that have impacted on your child or the family?

▫ Yes ▫ No Details: _____

_____

Has your child been in Out-Of-Home-Care in the past? ▫ Yes ▫ No

Is there any additional information that would be helpful for us to know to better support your child?

For example, are there any areas of difficulty or stress within the family such as: physical or mental health concerns, grief and loss, trauma, difficulty in family relationships, parenting stress, use of drugs or alcohol, involvement in the criminal justice system, work commitments, financial stress, impact of drought, practical difficulties.

▫ Yes ▫ No If Yes, please provide some details or you can let us know when we contact you.

_____
_____
_____
_____

CONSENT

I, _____(mother, father, guardian, other) give permission for the release of information to the Royal Far West regarding _____(child's name).

I understand that reports relevant to his/her assessment and/or treatment may be exchanged between Royal Far West, local schools, appropriate agencies and/or professionals.

Signature of parent or legal guardian:

Date:

Thank you for your cooperation, please return completed forms to Royal Far West PO Box 52, Manly NSW 1655 or e-mail to intake@royalfarwest.org.au

Form completed by

Your Name: Signature:

Your Relationship to Child: **Date:**