Rocky Bay
HEALTH + COMMUNITY

Form completed date:

Early Start Intervention Program (ESIP)

Referral Form 2025

Participant Details

Child's Name: _____

Child's Date of Birth: _____ Gender: ☐ Male ☐ Female

Home Address: _____

Suburb: _____ Post Code: _____

Primary Caregiver Details

Parent/Guardian Name: _____

Relationship to child: _____

Phone No: _____ Mobile: _____

Email Address: _____

Main language spoken at home: ☐ English ☐ Other Please specify: _____

Interpreter Required: ☐ Yes ☐ No Preferred time for contact: ☐ AM ☐ PM

Preferred Contact Method: Phone ☐ or Email ☐

Is the child a permanent Australian resident? ☐ Yes ☐ No

Is the child currently accessing funding under the NDIS? ☐ Yes ☐ No

Does the child identify as an Aboriginal or Torres Strait Islander? ☐ Yes ☐ No

Does the primary caregiver identify as an Aboriginal or Torres Strait Islander? ☐ Yes ☐ No

Is the child currently under the care of the Department of Child Protection and Family Support (CPFS)? ☐ Yes ☐ No

Referral Details

Primary Reason for Referral: _____

Does the child have a diagnosed disability, health concern and/or medical condition(s):

Please identify and mark the following criteria that are applicable:

- ☐ Less than 5 years of age
- ☐ With a diagnosis of a rare disease, genetic or chromosomal abnormality AND/OR
- ☐ Significant developmental delay and/or regression and two or more of the following risk factors identified

Please identify and mark the following risk factors that are applicable:

- ☐ Abnormal muscle tone including hypertonia, hypotonia, ataxia, dystonia and/or spasticity
- ☐ Congenital malformations or anomalies including craniofacial anomalies
- ☐ Diagnosed hearing and/or visual impairment
- ☐ Feeding difficulty/Failure to thrive (FTT)
- ☐ Hydrocephalus
- ☐ Microcephaly
- ☐ Musculoskeletal anomalies i.e tall or short stature, limb deformity, spinal deformity
- ☐ Proximal and/or distal significant muscular weakness, muscle atrophy or myopathy
- ☐ Prenatal Intrauterine Growth Restriction (IUGR)
- ☐ One or more birth defect
- ☐ Systemic illness i.e cardiovascular problems, metabolic disorders
- ☐ Abnormal brain MRI findings

Please select one or more of the following to indicate what type of support the child being referred requires

- ☐ Physiotherapy
- ☐ Occupational Therapy
- ☐ Speech Pathology
- ☐ Paediatric Feeding Team
- ☐ Paediatric Continence nursing
- ☐ Family and caregiver support
- ☐ NDIS and other system navigation

Other: _____

_____

Referrer Details

Please indicate who completed this referral form:

☐ Parent/Guardian ☐ Medical Professional ☐ Allied Health Professional

Other please specify: _____

If medical, health professional or other, please complete the following:

Name of Referrer: _____

Profession: _____ Place of Work: _____

Contact Phone Number: _____ Email: _____

- ☐ I (the referrer) declare that I have received consent from the parent/guardian of the child being referred to share client information with Rocky Bay, and the parent/guardian has consented to being contacted by Rocky Bay to obtain further information as required.
- ☐ I (the referrer) have attached relevant supporting documentation including written reports and clinical assessments with permission from the parent/guardian of the child.

How did you hear about us? _____

To assess eligibility for the ESIP, please complete the above referral form and send any supporting documentation to ESIP@rockybay.org.au fax: 08 **9383 1230** or mail: **PO Box 53, Mosman Park WA 6192**.

Rocky Bay HEALTH + COMMUNITY

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