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Supported by Funding through the Non School Organisations (NSO) Program



PHYSIOTHERAPY REFERRAL

SCHOOL FORM

Please complete all sections and return both School and Parent Forms to: studentservices@cns.catholic.edu.au

SECTION 1: STUDENT DETAILS

Last Name:		DOB:	
First Name:		Age:	
Verification Category:		Gender:	
Legal Guardian:		Year Level:	

SECTION 2: SCHOOL DETAILS

School Name:		Class Teacher:	
School Address:		Postcode:	

SECTION 3: PERSON COMPLETING THIS FORM

Name:		Date of Referral:	
Role:		Phone No:	
E-mail Address:			

SECTION 4: REASON FOR REFERRAL

ACCIST therapists focus on supporting the educational achievement of students verified through the Education Adjustment Program (EAP); please provide further student information:

<input type="checkbox"/>	Verified student through the Education Adjustment Program
<input type="checkbox"/>	Student with disability enrolled in Prep, awaiting verification through EAP
<input type="checkbox"/>	Student with complex physical needs
<input type="checkbox"/>	Student with high level needs in manual handling
<input type="checkbox"/>	Other – please discuss with therapist prior to completing this referral

Please describe the reason for the referral and your primary concerns:

What are the subsequent educational impacts for the student?

Please indicate the documents you have for this student that address the primary areas of concern:	
Document type	Document attached?
Personal Learning Plan (PLP)	
School report card	
Specialist report (e.g. paediatrician, external therapy services, hospital)	
Observational data	

SECTION 5: PREVIOUS INTERVENTION		
Has this student received intervention or supports at their current school?		
No – please provide reason:		
Yes – please summarise information using the table below		
Difficulties, barriers or concerns (e.g. gross motor, mobility etc)	Details of strategies trialled (when, where, timeframe, improvements, what did/did not work, why)	Others involved in supporting the student (e.g. diverse learners team, external services)

SECTION 6: ACKNOWLEDGEMENT					
<p>The focus of ACCIST services is to support students with verified disabilities to enhance their education outcomes. I support this referral and understand that:</p> <ul style="list-style-type: none"> - The student may be observed within the classroom - The student may be taken out of the classroom for brief periods - The therapist may communicate with the student's parent - Planning and feedback meetings may occur. <p>I acknowledge that as part of the educational team, I will be involved in the ongoing monitoring of this student's response to intervention.</p>					
Teacher name:		Signature:		Date:	
Learning Support name:		Signature:		Date:	