ACCIST
Cairns Catholic & Independent Schools Therapy
PO Box 5296 Cairns | (07) 40509722

Supported by funding through Special Disability Support in Schools (SDSS) program
SDSS
Proudly supported by the Department of Education
Queensland Government

CAIRNS CATHOLIC AND INDEPENDENT SCHOOLS THERAPY
SDSS SCHOOL REQUEST FOR SUPPORT FORM

INDEPENDENT SCHOOLS

Please complete all sections and return forms to: ewladmin@cns.catholic.edu.au

SECTION 1: STUDENT DETAILS			
Last name:		**DOB:**	
First name:		**Age:**	
Gender:			
Diagnosis:			

SECTION 2: SCHOOL DETAILS			
School name:		**School phone:**	
School e-mail:		**Class teacher:**	
School address:		**Year level:**	
CASE MANAGER			
Name:			
E-mail address:			

SECTION 3: PARENT / GUARDIAN			
Name:		**Relationship to student:**	
Address:			
Phone:			
E-mail address:			

SECTION 4: CULTURAL & LANGUAGE BACKGROUND		
Does the student identify as:		
☐ **Aboriginal**	☐ **Torres Strait Islander**	☐ **Other:**
Is English the student's main language?	☐ **Yes**	☐ **No**
Please list any other languages spoken at home (if applicable):		

SECTION 5: EVIDENCE OF ELIGIBILITY							
Student has been verified?	☐ **Yes**	☐ **No**	☐ **Awaiting verification**				
NOTE: if 'NO' was selected in the above answer, the student is not eligible for support services.							
Primary verification category:	☐ **HI**	☐ **VI**	☐ **PI**	☐ **ASD**	☐ **SED**	☐ **SLI**	☐ **ID**
Primary verification completed by:	☐ **State School**	☐ **Catholic Education**	☐ **Independent Schools Queensland**				
Primary verification date:	*(dd/mm/yyyy)*						
Other verification category: *(if applicable)*		**Other verification date:** *(if applicable)*					

SECTION 6: SCHOOL BASED SPECIALIST SERVICES		
Does the student access specialist education services at the school?		
☐ **Special Education Support**	☐ **AVT**	☐ **Therapy Services**
☐ **Special Education School**	☐ **Teacher Aide Support**	☐ **Other:**

SECTION 7: REASON FOR REQUEST FOR SUPPORT	
Primary Concerns:	**Educational, Access & Participation Impacts:**

What type of therapy service are you requesting to support this student?

- ☐ Assessment for information gathering by school team (stand-alone assessment)
- ☐ Classroom strategies and collaboration with classroom teacher (Tier 1 supports)
- ☐ Collaboration and support with targeted program adjustments (Tier 2 supports)
- ☐ Individualised program to be implemented by school staff (Tier 3 supports)
- ☐ Classroom resources/equipment
- ☐ Professional development/training
- ☐ Input into Personalised Learning Plans or attendance at team meetings
- ☐ Other (please specify):_____

Please indicate the documents you have for this student that address the primary areas of concern:			
Personal Learning Plan (PLP)	☐ **Yes**		☐ **Attached**
Relevant school policies and procedures (including student safety and mandatory reporting requirements)	☐ **Yes**	☐ **No**	☐ **Attached**
Specialist report (e.g. paediatrician, external therapy services, hospital)	☐ **Yes**	☐ **No**	☐ **Attached**
Other school-based documentation	☐ **Yes**	☐ **No**	☐ **Attached**

SECTION 8: SPECIALIST SERVICES

Has the student been assessed by/received therapy from any of the following professionals?
Please attach relevant reports if available.

Specialist:	Name:	Assessment/therapy dates:	Report attached?	Consent to contact?
Psychologist				
Speech Pathologist				
Occupational Therapist				
Paediatrician				
Physiotherapist				
Other				

SECTION 9: HEALTH		
Has the student's hearing been checked?	☐ **Yes, date of test & results:**	☐ **No**
Has the student's vision been checked?	☐ **Yes, date of test & results:**	☐ **No**

SECTION 10: SCHOOL CONSENT

Please indicate your consent by ticking the box beside the statements below:

- ☐ **I give permission for Cairns Catholic and Independent Schools Therapy (ACCIST) to provide services at our school, or as negotiated and agreed to by the above organisation and school.**
- ☐ **I understand that the SDSS services are to be provided in collaboration with the education professionals in the student's educational team.**
- ☐ **I understand that ACCIST will provide advice and support for the development and implementation of the student's Individualised Education Plan.**

Principal name:_____
(PLEASE PRINT)

Principal signature:_____

Date: _____

SECTION 11: PARENT / GUARDIAN CONSENT

Please indicate your consent by ticking the box beside the statements below:

- ☐ **I give consent for my child to receive therapy services from ACCIST as requested by the school. I understand that these services may include Speech Therapy, Occupational Therapy and Physiotherapy.**
- ☐ **I give consent for Therapists/Educators to discuss my child's learning needs with therapist from other support agencies (DET, Q Health, private therapists).**
- ☐ **I give consent for _____ (*NAME OF SCHOOL*) to release information regarding my child to the ACCIST. I understand that this may include reports from Occupational Therapy, Physiotherapy, Speech Therapy, Educator, IEP or School.**
- ☐ **I understand that information will be used by therapists to support my child's education and to complete the Support Data associated with funding requirements.**
- ☐ **I understand that assessment and/or follow-up services will be provided as required and appropriate, and that this may involve discussions with other agencies about my child.**
- ☐ **I give permission for a meeting regarding my child to proceed if I am unable to attend.**

There are court orders / custody arrangements which apply to my child:

☐ **Yes** | ☐ **No** | ☐ **Attached**

Parent/guardian name: _____
(PLEASE PRINT)

Parent/guardian signature: _____

Date: _____