In Home Baby Intervention Service (IBIS) Referral Form

PROUDLY SUPPORTED BY telethon 7

This form is for those seeking **Therapy services delivered by experienced Clinical Lead therapists** for children under 24 months of age.

For more information on this service please email IBIS@abilitywa.com.au Or call 1300 106 106.

Section 1 | Information about Referring

Part 1: Eligibility

To be eligible for the IBIS service the infant needs to be identified as being at risk and in need of specialist therapy support.

Some examples of risk factors include:

- Neurological insult confirmed on MRI or by neurological examination
- Extreme prematurity and/or birth weight of less than 1500g
- Family factors affecting their ability to attend clinic based services
- Child requiring immediate access to equipment

This service is also available to infants with a diagnosed disability or Global Developmental Delay who are awaiting access to NDIS.

Services will be provided to children up to 24 months of age.

Part 2: Service Area

This service is available in the Perth metropolitan area. Referrals from outer suburbs such as the shire of Kalamunda and the shire of Mundaring and the Mandurah Peel region will be considered on an individual basis.

Telehealth sessions can sometimes be offered to children living in outer suburbs, please call or email to discuss possible referrals outside of the service area.

Please provide any supporting documentation you have that will assist us to assess this referral.

Please send this form to Email: IBIS@abilitywa.com.au

You will receive a response email to confirm that we have received the referral. You will also receive a copy of the child's initial assessment report and exit report if the family consent to share the information.

Section 2 | Details of Individual Being Referred

Date of Referral:

Child's Contact Details:

Child's First Name:

Child's Surname:

Date of Birth: Male: ☐ Female: ☐

Centrelink No:

Primary Carer Details:

First Name:

Surname:

Relationship to child:

Home Address:

Suburb: Post Code:

Phone Number: Email Address:

Spoken Language: Interpreter Required: Yes: ☐ No: ☐

Additional Carer Details:

First Name:

Surname:

Relationship to child:

Contact details same as above: Yes: ☐ No: ☐

Home Address:

Suburb: Post Code:

Phone Number: Email Address:

Spoken Language: Interpreter Required: Yes: ☐ No: ☐

Is the child of Aboriginal or Torres Strait Islander Origin: Yes: ☐ No: ☐

Does the child have involvement with the Child Protection and Family Support (CPFS) Yes: ☐ No: ☐

Are there signs of parental stress, anxiety and/or depression: Yes: ☐ No: ☐

Are there any concerns for the safety of the therapist entering this home environment: Yes: ☐ No: ☐

Section 3 | Medical History

Reason for referral:
(please clearly outline the reason why this child requires at home therapy support)

Does any of the following criteria apply?
(Please mark the appropriate boxes and add comments)

Confirmed neurological insult on MRI or neurological examination: Yes ☐ No ☐
If yes, please provide details:

Born prematurely: Yes ☐ No ☐ No. of weeks: Birth weight:

Medical history:

Vision/hearing concerns: Yes ☐ No ☐
If yes, please provide details:

Current health or deformity risk or has significant pain: Yes ☐ No ☐
If yes, please provide details:

Experiencing seizures: Yes ☐ No ☐
If yes, please provide details:

Feeding concerns: Yes ☐ No ☐
If yes, please provide details:

Diagnosed disability – waiting to access NDIS: Yes ☐ No ☐

Does the child have any other health concerns or is there any other information you can provide to support the referral:

Medical or Therapy Report Attached: Yes ☐ No ☐

Please make sure that you attach any available medical or therapy reports

Section 4 | Referrer Details

Referrer Details:

Name:

Address:

Suburb: Post Code:

Phone Number: Email Address:

Relationship to child being referred:

Section 5 | Medical Practitioner Details

Same as Referred details: Yes ☐ No ☐

If No, please enter details below

Medical Practitioner Name:

Address:

Suburb: Post Code:

Phone Number: Email Address:

Section 6 | Consent for Referral

Collection:

I/we understand that the personal information and supporting evidence/documentation provided on this form is collected for the purpose of determining my child's eligibility to receive services.

Child's Name: DOB:

Parent/Legal Guardian's Name:

Use of Information:

I/We give consent to Ability WA to access reports and information regarding

to assess if he/she is eligible to receive services

Parent/Legal Guardian Full Name **Parent/Legal Guardian Signature**

- OR

Verbal Consent provided by family: ☐

Date: