

<p>SPEECH</p> <ul style="list-style-type: none"> <input type="checkbox"/> Speech/Articulation <input type="checkbox"/> Understanding / Comprehension <input type="checkbox"/> Vocabulary (oral) <input type="checkbox"/> Grammar (oral) <input type="checkbox"/> Narrative / Story telling (oral) <input type="checkbox"/> Expressing ideas / conversation <input type="checkbox"/> Phonics / Metalinguistics <input type="checkbox"/> Stuttering <input type="checkbox"/> Voice 	<p>OCCUPATIONAL THERAPY</p> <ul style="list-style-type: none"> <input type="checkbox"/> Eye-Hand coordination <input type="checkbox"/> Fine/Gross motor control <input type="checkbox"/> Visual perception <input type="checkbox"/> Sensory processing <input type="checkbox"/> Personal care (eg: toileting, feeding, dressing) <input type="checkbox"/> Equipment needs <input type="checkbox"/> School/home access 	<p>PODIATRY</p> <ul style="list-style-type: none"> <input type="checkbox"/> Foot deformity or lesion <input type="checkbox"/> Leg pain <input type="checkbox"/> Flat feet <input type="checkbox"/> Leg/foot problems eg toe walking/intoeing/bowlegs <input type="checkbox"/> Nail problems <input type="checkbox"/> Shoe fitting problem <input type="checkbox"/> Foot clumsiness/awkward movement
<p>DIETETICS</p> <ul style="list-style-type: none"> <input type="checkbox"/> Feeding difficulties <input type="checkbox"/> Failure to thrive/underweight <input type="checkbox"/> Gastroenteritis <input type="checkbox"/> Constipation <input type="checkbox"/> Diagnosed food allergy/intolerance <input type="checkbox"/> Gastro-oesophageal reflux <input type="checkbox"/> Overweight <input type="checkbox"/> Iron deficiency <input type="checkbox"/> Malabsorption condition 	<p>ABORIGINAL HEALTH WORKER</p> <ul style="list-style-type: none"> <input type="checkbox"/> Child health <input type="checkbox"/> Diabetes/Asthma <input type="checkbox"/> Medical Follow Up e.g. hypertension <input type="checkbox"/> Advocacy/Liaison e.g. appointments, transport <input type="checkbox"/> Sexual health <input type="checkbox"/> Ear, eye and dental health <input type="checkbox"/> Healthy lifestyles/environment 	<p>PHYSIOTHERAPY</p> <ul style="list-style-type: none"> <input type="checkbox"/> Plagiocephaly/Torticollis <input type="checkbox"/> Delayed milestones <input type="checkbox"/> Gross motor skills (eg. running, jumping, hopping, catching) <input type="checkbox"/> Balance <input type="checkbox"/> Toe walking or intoeing <input type="checkbox"/> Clumsiness or awkward movements <input type="checkbox"/> Musculoskeletal pain – eg pain in hips, knees <input type="checkbox"/> Scoliosis <input type="checkbox"/> Inactive child
<p>COMMUNITY NURSE</p> <ul style="list-style-type: none"> <input type="checkbox"/> Normal Development <input type="checkbox"/> Vision/hearing assessments <input type="checkbox"/> Asthma Educator <input type="checkbox"/> Diabetes Educator <input type="checkbox"/> Parenting issues i.e. sleep, Triple P <input type="checkbox"/> Maternal health i.e. breastfeeding, antenatal, postnatal. 	<p>SOCIAL WORK</p> <ul style="list-style-type: none"> <input type="checkbox"/> Family support and advocacy <input type="checkbox"/> Counselling <input type="checkbox"/> Practical assistance with community resources <p>CONTINENCE ADVISOR</p> <ul style="list-style-type: none"> <input type="checkbox"/> Enuresis <input type="checkbox"/> Encoporesis 	<p>MULTIDISCIPLINARY TEAM</p> <ul style="list-style-type: none"> <input type="checkbox"/> Feeding difficulties <input type="checkbox"/> Social skills <input type="checkbox"/> Play skills <input type="checkbox"/> Parenting support <input type="checkbox"/> Developmental Delay <input type="checkbox"/> High Priority – preterm birth/ low birth weight / perinatal risk factors

I give consent to the sharing of information with the members of the Child Development Team & *relevant* stakeholders (ie D.S.C, teaching staff etc) where it helps with the management of my child's health and wellbeing.

Yes Child Development Team and Stakeholders.

Yes Child Development Team only.

No Consent

Parent/Guardian Signature _____

Referred by:

Date:

Referee Contact Details (Email or PO Box):

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