Developmental Disability Assessment Team (DDAT) Referral Form

Health
South Eastern Sydney
Local Health District

ALL 4 ELIGIBILITY CRITERIA MUST BE MET:

1. Concerns for GDD &/or ASD
2. Not yet started school
3. Resides within SESLHD (*South of Sydney Kingsford Smith Airport to Waterfall)*
4. Referrals only accepted from Healthcare providers

INSTRUCTIONS:

1. All fields on Pages 1 & 2 are compulsory &

2. Use Appendix A as a framework **OR** Attach a Clinical Referral Letter that: * is addressed to DDAT * details developmental concerns: communication, fine & gross motor, social & emotional, play, self care and behaviour; observed or reported behaviours related to GDD &/or ASD and * referrals & information provided to the family.

*NOTE: A Clinical Referral Letter is **not** an intervention summary or assessment report.*
Clinical Referral Letters with insufficient information will be returned for further information to be provided. This may delay a child's appointment.

1. Referrer details / Healthcare provider completing this form

Date:	**First name:**	**Surname:**
Practice name:	**Practice address:**	
◯ **Paediatrician**	◯ **Speech Pathologist**	◯ **Occupational Therapist** ◯ **GP** ◯ **Other healthcare provider:**
Phone:	**Fax:**	**Email:**
Do you have consent to refer this child?	◯ **Yes**	◯ **No**

2. Child details

Surname:	**First name:**	**MRN (if known):**
DOB:	**Current age:**	**Gender:**
Residential address:		**Postcode:**

Residency status: ◯ Australian Citizen Permanent resident ◯ Overseas Visitor ◯ Student Visa Type: ◯ Refugee/Asylum Seeker ◯ Other Visa

Medicare eligible: ◯ Yes ◯ No	**Medicare number:**

Is this child of: ◯ **Aboriginal or Torres Strait Islander** ◯ **Neither** ◯ **Unknown**

Interpreter required for the child: ◯ **Yes** ◯ **No** **Language:**

Are there any complexities for this child: ☐ Out of Home Care ☐ Department of Housing ☐ Court or Parenting orders ☐ Case worker /Agencies

Details:

What year is the child starting school?	**Which school?** (school finder)

Is the child accessing NDIS (ECEI/Early Childhood Approach)? ◯ **Yes** ◯ **No** ◯ **Awaiting approval**

3. Parent/Person responsible information

Primary contact:	◯ Mother ◯ Father ◯ Legal guardian	**Title:**	◯ Mr ◯ Mrs ◯ Ms ◯ Miss Other:
Surname:		**First name:**	
Residential address:			**Postcode:**
Home phone:		**Mobile:**	
Email:			
Interpreter required:	◯ **Yes** ◯ **No**	**Language:**	

Send completed referral form &/or clinical referral letter + available reports to: SESLHD-DDAT@health.nsw.gov.au or F: 9588 3135

4. Reason for referral

What are you wanting from this child's referral?

Do you have concerns for:

Possible Global Developmental Delay or Intellectual Disability? ◯ Yes ◯ No

Possible Autism Spectrum Disorder? ◯ Yes ◯ No

Please detail any relevant health history and pre-existing diagnosis:

Other information e.g. family circumstances/challenges:

5. Services and consent

Please list professionals currently or previously involved with this child and family:

Profession	Name/Facility	Active/Inactive	Report available
GP		◯ Active ◯ Inactive	◯ Yes ◯ No
Paediatrician		◯ Active ◯ Inactive	◯ Yes ◯ No
Speech Pathologist		◯ Active ◯ Inactive	◯ Yes ◯ No
Occupational Therapist		◯ Active ◯ Inactive	◯ Yes ◯ No
Child Health Nurse		◯ Active ◯ Inactive	◯ Yes ◯ No
Day care/Pre school		◯ Active ◯ Inactive	◯ Yes ◯ No
Psychologist/ Behaviour support		◯ Active ◯ Inactive	◯ Yes ◯ No
Physiotherapist		◯ Active ◯ Inactive	◯ Yes ◯ No
ENT		◯ Active ◯ Inactive	◯ Yes ◯ No
Dietitian		◯ Active ◯ Inactive	◯ Yes ◯ No
Audiologist		◯ Active ◯ Inactive	◯ Yes ◯ No
Key worker		◯ Active ◯ Inactive	◯ Yes ◯ No
Play group		◯ Active ◯ Inactive	◯ Yes ◯ No
Other		◯ Active ◯ Inactive	◯ Yes ◯ No
Parent/guardian consent for DDAT to contact & release information to/from listed professionals?			◯ Yes ◯ No

6. Signature of healthcare referrer

Name:	Date:
Signature:	

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APPENDIX A

If a DETAILED Clinical Referral Letter addressing areas of developmental concern is attached, APPENDIX A does not need to be completed.

7. Please identify and provide DETAILED information for ALL areas of development:	
Gross motor	**Fine motor**

Communication LANGUAGE

- Does the child:

Understand questions? ◯ Yes ◯ No Describe:

Understand instructions? ◯ Yes ◯ No Describe:

How does the child express themselves most of the time? ☐ Gestures ☐ Vocalisations/noises

Does the child: ☐ use single words ☐ 2- 3 word phrases ☐ Sentences ☐ Have a conversation that flows

Describe:

SPEECH *(the sounds that make up words)* **concerns:**

Social *(Initiates interaction, shows empathy, responds to others)*

Play *(Pretend play, solo play)*

Pre academic skills *(Counting, colours, puzzles, memory)*

Functional skills/self-help *(Toileting, washing hands, dressing, feeding)*

Diet *(Restrictions, known deficiencies)*

Sleep *(Snoring, breathing pauses during sleep, trouble falling asleep, difficulty staying asleep, waking tired)*

Behaviour *(Emotional regulation/sensory, personal safety, self-injurious behaviours)*

This APPENDIX was completed by:

Thank you. Your referral will be processed by DDAT's clinical team. We will contact you with an outcome.

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