EDUCATIONAL CASE MANAGEMENT

CLINICAL ALLIED HEALTH SERVICES

info@ecmonhudson.com 02 4969 8060 www.ecmonhudson.com

REFERRAL FORM BEHAVIOUR SPECIALIST | ALL AGES

Title: Dr Mr Mrs Ms Master Miss Other:

Last Name: First Name: Middle Name:

Preferred Name: Date of Birth:

Sex: Male/Female/Intersex/Other: Male Female Intersex Other Pronouns:

Do you identify as Aboriginal: Yes No and/or Torres Strait Islander: Yes No

Home Address:

Suburb: State: Postcode:

Mobile No: Work No: Email:

Text: Yes No Email: Yes No Can we leave a voicemail? Yes No

Siblings Name(s) and Ages

Have you ever attended an Educational Case Management clinic? Yes No

EDUCATION / EMPLOYMENT

Do you attend school? Yes No Name of School: Year:

Are you currently undertaking Tertiary Education? Yes No

Are you currently employed? Yes No Place of Work: Occupation:

GENERAL PRACTITIONER

GP Name:

Practice Address:

Phone: Email:

Do you have a Care Plan from your GP or Specialist: Yes No Who has referred you to ECM: GP Specialist

Organisation: Yes No Name of Organisation:

NDIS Provider: Yes No Name of Provider:

INSURANCE INFORMATION

Medicare Card Number: Number on Card: Expiry:

Pension/Health Card Number: Yes No Card Number: Expiry:

Private Health Insurance: Yes No Private Health Provider Name:

Private Health Insurance Card Number Number on Card:

Are you on the National Disability Insurance Scheme Yes No NDIS Number:

NDIS Self-Managed: Yes No NDIA Managed: Yes No PACE Managed: Yes No

Plan Managed: Yes No Please provide Plan Manager's Name:

EMERGENCY CONTACT- LEGAL GUARDIAN/PARENT INFORMATION OR NEXT OF KIN

Full Name: | Relationship to client:

Home No: | Mobile No: | Work No:

Email Address:

Suburb: | State: | Postcode:

Text: Yes No Email: Yes No Can we leave a voicemail? Yes No

FAMILY DETAILS (IF APPLICABLE)

1. Parent/Carer/Guardian Details

Parent Name: | Mobile:

Address:

Family History Mental Health: Yes No Diagnosis:

Family History Learning Problems: Yes No Diagnosis:

Are there current Parenting Orders: Yes No Please Describe:

2. Parent/Carer/Guardian Details

Parent Name: | Mobile:

Address:

Family History Mental Health: Yes No Diagnosis:

Family History Learning Problems: Yes No Diagnosis:

Are there current Parenting Orders: Yes No Please Describe:

MEDICAL INFORMATION

Special medical needs, conditions, diagnosis, illnesses, allergies: Yes No

Describe:

Medical History:

Are you currently on medication: Yes No Current Medication:

Does the client require any extra support when attending the clinic? Yes No Communication

Behaviour Mental Health Medical Condition Physical Access Completing Forms (Easy Read Version) Interpreter

PLEASE SELECT BEHAVIOUR SUPPORT REQUIREMENTS

Formulation of Interim/Comprehensive Behaviour Support Plan	Yes	No
Behaviour Management, Strategies & Recommendations	Yes	No
Review of Restrictive Practices	Yes	No
Ongoing Behaviour Therapy	Yes	No

Other, please specify:

ARE THERE ANY RESTRICTIVE PRACTICES? (IF APPLICABLE)

Chemical ☐ Yes ☐ No Describe:

Mechanical ☐ Yes ☐ No Describe:

Environmental ☐ Yes ☐ No Describe:

Seclusion ☐ Yes ☐ No Describe:

Physical ☐ Yes ☐ No Describe:

Unsure ☐ Yes ☐ No Describe:

NDIA GOALS

1.

2.

3.

4.

BEHAVIOURAL CONCERNS (IF APPLICABLE)

- [ ] Wandering (exit-seeking)
- [ ] Physically Responsive Behaviour (spit, kick, grab, push, scratch, bite etc.)
- [ ] Sexualized behaviour
- [ ] Suicidal behaviour
- [ ] Resists Care (medications)
- [ ] Verbally responsive behaviour (yelling, screaming, threatening, cursing etc.)
- [ ] Agitated behaviour (restless, anxiety, inability to settle)
- [ ] Delusions (fixed, false beliefs)
- [ ] Hallucinations (visual, auditory, gustatory, tactile, olfactory)
- [ ] Fidgeting/picking/repetition
- [ ] Calling out, crying
- [ ] Hoarding (collecting objects and refusing to part with them)
- [ ] Oral intake of non-edible items/substances
- [ ] Low Mood/Depressed (crying, tearfulness, reduced social interaction, loss of interest/pleasure)
- [ ] Rummaging (touching/handling objects with no obvious purpose
- [ ] Other:

- [ ] Significant Caregiver Stress/difficulty coping

ADDITIONAL COMMENTS

Please let us know about any additional needs or requirements.

Does the Participant have a Support Coordinator? ☐ Yes ☐ No

Name of Support Coordinator:

BANK DETAILS (AUTOMATIC PAYMENT FOR SERVICES)

Bank Account Name:

Bank Account Number: BSB Code:

Or

Credit Card (Name on card): Expiry Date:

Card Number: CVC:

Fees:

Fees (consultations, telehealth, therapy, groups, reports, and resources) are payable at the time the service is provided. A $80.00 deposit is required when the initial consultation is scheduled by the Administration Team. Fees will vary depending on Allied Health Professionals discipline hourly rates ranging from $185 to $270. Report fees will depend on Allied Health Professionals discipline hourly rates and will be governed by a time frame from 1 hour (Summary Reports) to 12 hours (Psychological, Functional and/or Behavioural Reports). Supports for participants under the National Disability Insurance Scheme (NDIS) will be subjected to NDIS Pricing Arrangements and Price Limits 2024-2025- charged at the hourly rate specified for each discipline. Please visit https://www.ecmonhudson.com for information regarding Allied Health Professional Services and Fees.

Cancellation Policy:

ECM has put in place a cancellation policy to ensure that enough time is provided to offer the appointment time to another client. If less notice is provided, other clients may miss out on obtaining the services they require. Amendments to appointments must be made via phone (02 4969 8060) or via email (info@ecmonhudson.com) and must be made within 2 business days of the appointment scheduled. A Debt Collection service may be used to collect outstanding debts if not paid. A 100% consultation fee will occur if ECM is not notified within 2 business days. This also applies to participants supported by the NDIS and includes cancellations, rescheduling, or failure to attend appointments.

Privacy and Confidentiality

All personal information, assessment results, and documentation collected by ECM Allied Health Professionals is confidential. All documentation is stored securely and locked with Zanda Management password system and Authenticator, and can only be accessed by the ECM clinicians treating the client and/or administration team who are also bound by confidentiality.

Limitations to confidentiality

All personal information gathered by the therapist during the provision of therapeutic services will remain confidential except when:

1. It is subpoenaed by a court; or
2. Suspected or reported risk of harm to self or others (i.e. suicidal or self-harm ideation/plan/intent; homicidal ideation/plan/intent); or
3. Criminal act requiring reporting to the Policing Services; or
4. Current alleged or actual observed abuse, harm or neglect to a client requiring reporting to authorising bodies as per NDIS Practice Standards (this could include, for example, Child Safety/ Protection bodies across States and Territories or the NDIS Quality and Safeguarding Commission); or
5. Your prior approval has been obtained to: a. provide a written report to another professional or agency. e.g. GP, school or a lawyer; or b. discuss the material with another person, e.g. a parent, employer or health provider; or c. disclose the information in another way.

Please note ECM are mandatory reporters and obligated to report ALL suspicions and allegations of abuse. GP's require review letters throughout the year that often include a summary of sessions. For those on the NDIS, it is a requirement to provide (at a minimum) a progress report at each review stage.

Emergency Contacts

Please note we are not an emergency service; our phones and emails are not constantly monitored. In an emergency situation please contact 000 for police/ambulance.

- Police or Ambulance - 000
- Mental Health - 13 14 65 Lifeline - 13 11 14 or www.lifeline.org.au
- Kids Helpline (5-25 years) - 1800 55 1800 or www.kidshelpline.com.au
- Suicide call back service - 1300 659 467 or www.suicidecallbackservice.org.au

Please email info@ecmonhudson.com or call 02 4969 8060 if you have any questions about this form. Please bring all reports and relevant information to your initial consultation.

I (Print Name) ☐ give / ☐ do not give permission for ECM to Forward the ECM Newsletter and updates to the recorded email address.

CONSENT

I (Print Name) confirm that I have read the information and that information provided is accurate to my knowledge. I consent for ECM to provide treatment &/or service, retain information on their secured and confidential data base and share (if necessary) with Medical Practitioner/Specialist for the purpose of reporting on a condition after assessment and/or treatment (if required).

I have signed the Informed Consent form

☐ Yes ☐ No

Client Signature: Date:

If client is under 18 years of age Parent/ Carer/Guardian/Responsible Person:

Name: Signature: Date: