



ecm

EDUCATIONAL CASE MANAGEMENT CLINICAL ALLIED HEALTH SERVICES

✉ info@ecmonhudson.com

☎ 02 4969 8060

🖱 www.ecmonhudson.com

REFERRAL FORM

SOCIAL WORK

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 Interpreter

Behaviour	Mental Health	Medical Condition	Physical Access	Completing Forms (Easy Read Version)	Interpreter
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WHY DO YOU NEED A SOCIAL WORKER

1. Has the client received any therapeutic social work services previously Yes No

Please name clinic/organization: _____ Date: _____

2. What type of Social Work service is required (select all that apply)

Psychosocial Assessment Yes No

Ongoing Social Work Services Yes No

Home Support Yes No

Accessing Community and/or Educational Supports Yes No

Family Therapy Yes No

Safety and/or Risk Assessment Yes No

Conflict Resolution (Relationships) Yes No

Relationships Skills Yes No

(Understanding/improving/navigating family relationships); Understanding/improving/navigating sibling relationships; Understanding/improving/navigating personal relationships; Developing friendships),

Better understanding of a diagnosis (strengths and less developed areas)	Yes	No
Increasing independence and skill development	Yes	No
Employment Support	Yes	No
Supporting with life planning (Educational pathways)	Yes	No
Managing household duties and organization	Yes	No
Developing confidence and self-esteem	Yes	No
Developing a sense of identity (better understanding gender identity)	Yes	No
Developing positive sense of self	Yes	No
Need to build resiliency (managing crisis and developing resilience); Developing coping strategies	Yes	No
Developing problem solving skills	Yes	No

BACKGROUND INFORMATION

1. Please describe the client's current living situation: (e.g. lives independently, lives with others, lives with family an level of support provided)

2. Please describe the client's level of support currently being provided (if applicable)

Supported provided by:

Contact person:

COMMUNICATION

How does the client currently communicate?

High-level language use and is age-appropriate	Yes	No
Spoken language (phrases and sentences)	Yes	No
Spoken language but with limited ability to use language functionally to get needs met	Yes	No
Non-speaking	Yes	No
Uses gestures/body language to communicate	Yes	No
Uses visuals or other AAC	Yes	No

BEHAVIOURAL MANAGEMENT

Does the Client have a current Positive Behaviour Support Plan?	Yes	No
Behavioural Specialist Name:	Contact details:	
Does the client exhibit inappropriate behaviours	Yes	No
Physical Aggression	Yes	No
Property Damage	Yes	No
Absconding	Yes	No
Psychiatric issues	Yes	No
Emotionally Disregulated	Yes	No
Unpredictability	Yes	No
Limited Self Awareness	Yes	No
Other (Please describe):	Yes	No

Please list the known triggers that may be associated with client's behaviours:

RISK MANAGEMENT

Does the Client have a current Risk Assessment	Yes	No
Risk Assessor Name:	Contact details:	
Is the client well managed by current risk assessment plan (if applicable)	Yes	No
Please describe:		

BANK DETAILS (AUTOMATIC PAYMENT FOR SERVICES)

Bank Account Name:
Bank Account Number:

BSB Code:

Or

Credit Card (Name on card):
Card Number:

Expiry Date:

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.

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.

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.

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.

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.

- 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

Limitations to confidentiality

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

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: _____