ecm

EDUCATIONAL CASE MANAGEMENT
CLINICAL ALLIED HEALTH SERVICES

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

REFERRAL FORM ADULT SPEECH PATHOLOGY

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

MAIN CONCERNS

DEVELOPMENTAL HISTORY: (IF RELEVANT)

Language	Delayed	Age Appropriate	Advanced
Combining 2-3 words:			
Making a sentence:			
Understanding directions:			
Motor Skills	**Delayed**	**Age Appropriate**	**Advanced**
Walk:			
Self-feed:			
Go to the toilet:			

DEVELOPMENTAL HISTORY: CONTINUED...

Feeding History	Delayed	Age Appropriate	Advanced
Eating solids:			

Eating Difficulties	Delayed	Age Appropriate	Advanced
Chewing food:			
Swallowing liquids:			
Current/previous drooling:			

Diet - Please describe

Hearing	Y	N
Frequent ear aches:		
Frequent colds:		
Previous hearing assessment:		
Hearing aids:		
Grommets:		

MEDICAL / ASSESSMENT HISTORY

Has you been assessed by any of the following professionals?
If yes please provide a copy of report.

Neuro-Psychologist	Yes	No
Psychologist	Yes	No
Endocrinologist	Yes	No
Speech Pathologist	Yes	No
Occupational Therapist	Yes	No
Behavioural Optometrist	Yes	No
Audiologist	Yes	No
Immunologist	Yes	No

PRESENTING CONCERNS

1) Expressive Language

- Difficulty asking for help
- Difficulty with asking questions
- Has trouble expressing thoughts
- Has trouble describing things to people (e.g. forgets some of the information)
- Uses poor grammar when talking
- Gets upset when people don't understand
- Difficulty sequencing events (e.g. putting events in the right order when telling a story)
- Lacks facial expressions, gestures or body language
- Limited vocabulary (e.g. doesn't use a variety of words when talking)
- Repeats words or sentences more than once
- Gets 'stuck' on words
- Unable to speak in complete sentences (e.g. misses some words)

2) Receptive Language

- Difficulty following spoken directions / instructions (e.g. gets confused or forgets easily)
- Trouble remembering what people say
- Difficulty understanding the meaning of words
- Difficulty understanding new ideas

3) Speech (articulation of sounds)

- Unfamiliar listeners have difficulty understanding you (i.e. speech intelligibility)
- Gets certain sounds mixed up when talking (e.g. says 'w' for 'r')

4) Social

- Aware of the difficulties they are facing
- Poor eye contact (e.g. looks away or down when talking to others)
- Difficulty making new friends
- Seems less mature than their peers
- Poor turn taking skills when interacting
- Often refuses to go to attend social activities
- Prefers to play alone (e.g. avoids after school play, avoids playground, avoids interaction with others)
- Reluctant to talk to peers (e.g. doesn't interact, stands back, allows others to take control)
- Talks about inappropriate things (e.g. seems immature, talks about own interests)
- Lacks facial expressions or gestures when communicating

PRESENTING CONCERNS AT HOME AND AT SCHOOL

5) Auditory Processing

- Does not listen to directions
- Does not respond to name
- Needs extra time to respond to questions
- Sometimes misunderstands what is said
- Responds with “huh” or “what” in response to questions

6) Sensory

- Difficulty avoiding objects in the way (e.g. trips over toys, walks into things)
- Does not respond well to loud noises
- Dislikes noisy settings (e.g. hates crowded areas)
- Does not respond well to certain food and clothing textures (e.g. rough surfaces, wearing socks, mashed potato)
- Dislikes having teeth/hair brushed

7) Behaviour

- Is argumentative (e.g. continual confrontations)
- Seems to lack empathy (e.g. displays little concern over others)
- Self-harms (e.g. hitting head, picks skin, pulls hair)
- Struggles to conform (e.g. consistently defiant, ignores the word ‘no’)

8) Mental health

- Low self-esteem (e.g. doubts themselves)
- Lack of confidence (e.g. presents as shy, easily intimidated)
- Can become easily irritated/frustrated
- Prefers to be alone

9) Attention/concentration/organization

- Presents as selectively inattentive (e.g. highly attentive when using technology
- Becomes bored easily (e.g. needs constant stimulation, struggles with objects they find difficult)
- Has difficulty completing tasks (e.g. can’t concentrate)
- Struggles to sit still for long periods of time (e.g. fidgets, hyperactive, impulsive)
- Is easily distracted (e.g. can’t study with background noise, always feels they are missing out)
- Has difficulty organising self (e.g. poor executive functioning, needs constant reminding)

10) Gross and fine motor skills

- Avoids sports
- Appears uncoordinated
- Poor hand writing (e.g. unable to write on the line, writes letters backwards, untidy)
- Appears to be slow when writing (e.g. complains of a sore hand/arm)

11) Literacy/learning

- Has difficulty expressing ideas in writing
- Has trouble identifying letters/sounds
- Reverses letters/numbers, writes words backwards, writes letters out of order
- Has difficulty sequencing letters and words when writing
- Experiences difficulty with the ‘mechanics’ of writing (e.g. spelling, punctuation)
- Is a slow reader
- Difficulty understanding what has been read (e.g. has to re-read information several times)

ADDITIONAL INFORMATION

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: