Flying Start Mudgee Therapy referral form

Flying Start Mudgee is a free allied health program in your community. We have a Speech Pathologist and Occupational Therapist who can provide assessment and intervention to individual children and with families to help children thrive.

## Who is eligible?

* Children aged 0-7 who need help meeting developmental milestones (eg talking, playing, toileting)
* Children who are living in or accessing services in the Mudgee region

## Accessing the program

Complete the referral below and email to [FlyingStartMudgee@marathonhealth.com.au](mailto:FlyingStartMudgee@marathonhealth.com.au) or head to **marathonhealth.com.au/flying-start-mudgee** to complete the referral online.

If you need help completing the referral form or have questions about making a referral, contact our Clinic Coordinator on 0419 740 768.

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| **Form completed by** |  | **Date completed** |  |
| **Requested service** | Speech Pathology  Occupational Therapy | | |

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| **Child details** | | | | | |
| Legal first name: | | | Legal surname: | | |
| Preferred name: | | Date of Birth: | Gender: | | Pronouns: |
| Culture  (select all that apply) | Aboriginal  Torres Strait Islander  Neither Aboriginal nor Torres Strait Islander  Other (please specify) | | | | |
| Address: | | | | Suburb: | |
| Postcode: | | Phone: | Email: | | |

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| **Guardian/Carer details** | | | | |
| Parent  Guardian  Carer  Public guardian  Other | | | | |
| Name: | Preferred contact: | Phone | Email | Both |
| Phone: | Email: | | | |

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| --- | --- |
| **School/childcare centre attendance details** | |
| School, preschool or childcare centre name: |  |
| Days attended:  Monday  Tuesday  Wednesday  Thursday  Friday | |
| Teacher name (if known): |  |

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| --- | --- |
| **GP details** | |
| GP name: | |
| GP Practice: | Mudgee Medical Centre  South Mudgee Surgery  Other *(please specify)* |

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| **Consent** | | | |
| I give consent for my child to access the Mudgee Flying Start service | | Yes  No | |
| I give consent for the Mudgee Flying Start team to talk to other professionals and people involved in my child's life to get information needed for the appointment | | Yes  No | |
| Provided by: | Signed: | | Date: |

|  |  |
| --- | --- |
| **Do you need communication assistance? Eg Interpreter, communication device** | |
| Yes *(please describe)* | No |

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| **Reason for referral to the Flying Start Mudgee clinic:**  List developmental concerns or delays |

**Please ask the family these questions**

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| --- | --- |
| **Is the child on the NDIS or Early Childhood Approach?** | Yes  No |
| **Has the child seen an Occupational Therapist (OT) in the last 12 months?** | Yes  No |
| **Has the child seen a Speech Pathologist in the last 12 months?** | Yes  No |