Referral Questionnaire - Parent

About your child

Your child's name _____

Preferred name (if different) _____

Date of birth _____ Gender (M) (F) (Other)

School / preschool / kindergarten _____

How many years has he/she been there? _____ Grade _____

About you and your family - We understand there are many possible family arrangements, please modify this as is appropriate for your family.

Mother's name _____

Email _____

Father's name _____

Email _____

Main contact person _____

Are you separated or divorced? (Y) (N) If yes, we will need to understand your parenting arrangements

Home address _____

Phone
Home _____ Mother _____ Father _____

Medicare -Parent _____ Child _____

What does your child enjoy, do well, what do you love about them?

Overall, how concerned or worried are you about your child at the moment?

	Not at all	A little	Moderately	Very
Mother	[ ]	[ ]	[ ]	[ ]
Father	[ ]	[ ]	[ ]	[ ]

Please describe what you are most concerned about.

What would you like our help with **to understand** about your child?

What would you like to **achieve** (for your child), and would like our help with?

* In the immediate future

* Further into the future (in the longer term)

Is there anything else in particular you would like to discuss with us?

Health History- please indicate if there are concerns or issues regarding:

	Yes	No
Your child's health at the moment	[ ]	[ ]
The pregnancy, birth, postnatal period	[ ]	[ ]
Serious accidents / injuries / illnesses	[ ]	[ ]
Hearing: Has your child's hearing been tested?	[ ]	[ ]
Vision: Has your child's vision been tested?	[ ]	[ ]
Immunisation: Is your child fully immunised?	[ ]	[ ]

What was your child's Birth Weight? _____

If your child was premature, how many weeks? _____

Anything else of ***health*** concern for your child, that may be important to discuss with us?	[ ]	[ ]

Developmental History- as your child grew, were you concerned about:

The first year (e.g. hard to settle, poor sleep, weight gain)	[ ]	[ ]
Your ability to 'connect' or 'attach' to your child?	[ ]	[ ]
Early milestones (e.g. walking, talking)	[ ]	[ ]
Early learning (e.g. colours, counting, shapes, drawing)	[ ]	[ ]
Any other concerns you would like to discuss?	[ ]	[ ]

Family History- does anybody in the family have:

Problems / difficulties ***same*** or similar to your child?	[ ]	[ ]
Problems / difficulties ***different*** to those of your child?	[ ]	[ ]

Concerns- If you identified concerns above, what would you like to discuss?

_____

_____

_____

_____

Professional Services- Who have you worked with in the past to understand and manage your child's difficulties?

This may include doctors, psychologists, therapists, special education services, tutors, and any other professionals who has cared for your child.

Name	Profession	When (years)

If you have any professional ***reports or letters***, please bring them along. Where possible, please make a copy for us.

	Yes	**No**
At the consultation, is there sensitive information that you would prefer ***not*** to talk about in front of your child?	** [ ] **	[ ]

**** Note **** If you wish to discuss matters whilst your child is outside in the waiting area, please prepare for this.

- If they can manage alone, please bring something for them to do.
- If they need supervision, pleas bring somebody who is able to mind and supervise them.

Completed by (Name, Date) _____

If there is anything further you would like to share or discuss with us, please note this down on the back of this page.

Thank you

Developmental Medicine Consulting