



PATCHES Client Information Form

PATCHES provides clinical diagnostic services for Fetal Alcohol Spectrum Disorder (FASD), Autism Spectrum Disorder (ASD), Intellectual Disability (ID), Global Developmental Delay (GDD), and other behavioural and cognitive conditions.

Eligibility for diagnostic services include:

- Referral by a GP and/or paediatrician using a GPMP, TCA and/or GPMHCP **(Required)**
- Ability to fund assessment: Private pay or agency-funded (CPFS, Justice, Grant based program)
- **Client information form completed by the family, carer or legal guardian.**

Send the completed form to diagnosis@patches-paediatics.com.au or Fax : **08 6208 3202**

Client Details									
Family Name									
Given Names									
Other names									
Date of birth	/	/		Hospital of Birth:					
Biological Mothers Name									
Ethnicity						Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other			
ATSI Status	<input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Both <input type="checkbox"/> Neither								
Preferred Spoken Language									
CRN									
Parent/Carer Name						Ph:			
Relationship to Patient						ATSI Status: <input type="checkbox"/> Aboriginal <input type="checkbox"/> TSI <input type="checkbox"/> Both <input type="checkbox"/> Neither			
Residential Address									
Postal Address									
Email Address									
Person Completing Referral						Ph:			
Relationship to Patient									
Postal Address									
Medicare Card Number									
IRN (place on card e.g. 3)				Expiry Date					
Additional Details									
Previous Diagnoses									
This referral is for assessment of <input type="checkbox"/> FASD <input type="checkbox"/> Global Developmental Delay <input type="checkbox"/> Autism <input type="checkbox"/> Other:									
Patient in care of Child Protection & Family Support				Y <input type="checkbox"/> N <input type="checkbox"/>		Case Worker:			
Contact Details	Email:					Ph:			
Patient known to Disability Services Commission				Y <input type="checkbox"/> N <input type="checkbox"/>		Local Coordinator:			
Contact Details	Email:					Ph:			

Patient known to Child Development Services		Y <input type="checkbox"/> N <input type="checkbox"/>	Service:
Contact Details	Email:		Ph:
Patient known to Aboriginal Health Service		Y <input type="checkbox"/> N <input type="checkbox"/>	Service:
Contact Details	Email:		Ph:
Patient known to Corrective Services		Y <input type="checkbox"/> N <input type="checkbox"/>	Youth Justice Officer:
Contact Details	Email:		Ph:
Current School Enrolment			
School/Kindy/Day Care Centre			Year Level:
Teacher/Educator Name			Ph:
Teacher Contact Details	Email:		
Regular Attendee (80% or more)	Y <input type="checkbox"/> N <input type="checkbox"/>	If No, Approximate Attendance: _____ %	
Academic Performance at school compared to peers:			
Are there concerns with attention and/or hyperactivity at school? Y <input type="checkbox"/> N <input type="checkbox"/> (if yes, please describe)			
Are there concerns with social functioning at school? Y <input type="checkbox"/> N <input type="checkbox"/> (if yes, please describe)			
Are there concerns with emotional functioning at school? Y <input type="checkbox"/> N <input type="checkbox"/> (if yes, please describe)			
Are there other concerns at school? Y <input type="checkbox"/> N <input type="checkbox"/> (if yes, please list)			
Strengths, interests and goals:			

Speech Pathology

Has the Patient had Speech Therapy treatment or assessments in the past?

Y ☐ N ☐

If yes – Service(s):

Contact Details:

Current Concerns (please list)

Speech/Articulation

Language

Comprehension/Understanding

Spoken Language

Phonological Awareness/Literacy

Social Skills

Stuttering (Length of Time)

Voice

Feeding/Eating/Swallowing

Occupational Therapy

Has the Patient had Occupational Therapy treatment or assessments in the past?

Y ☐ N ☐

If yes – Service(s):

Contact Details:

Current Concerns (please list)

Eye-Hand Coordination

Fatigues During Tasks

Difficulty with Pencil/Scissor Skills

Difficulty Copying or Reading from a board

Sensory Processing (e.g. difficulty with concentration or fidgety)

Personal Care (e.g. toileting, dressing)

Physiotherapy

Has the Patient had Physiotherapy treatment or assessments in the past?

Y ☐ N ☐

If yes – Service(s):

Contact Details:

Current Concerns (please list)

Not Reaching Motor Milestones

Clumsiness

Moving Awkwardly

Poor Posture

Poor Gross Motor Skills	
Poor Ball Skills	
Biomechanical (e.g. hip, foot dysfunction)	

Psychology

Has the Patient had Psychological treatment or assessments in the past?	Y <input type="checkbox"/> N <input type="checkbox"/> If yes – Service(s): Contact Details: Current Concerns (please list)
Behavioural Concerns	
Cognitive Difficulties	
Related History	

Development

Has the Patient had developmental assessments in the past?	Y <input type="checkbox"/> N <input type="checkbox"/> If yes – Service(s): Contact Details:
Were there any concerns during the pregnancy with your child? Y <input type="checkbox"/> N <input type="checkbox"/> (If yes, please list)	
Did the child's mother use alcohol or other drugs during pregnancy? Y <input type="checkbox"/> N <input type="checkbox"/> (If yes, please give details)	
Was your child born to full term? Y <input type="checkbox"/> N <input type="checkbox"/> At how many weeks' gestation were they born?	
Did your child have any health concerns at birth or before their first birthday? Y <input type="checkbox"/> N <input type="checkbox"/> (If yes, please list)	
Did you ever have any concerns about your child's development? Y <input type="checkbox"/> N <input type="checkbox"/> (If yes, what were you concerned about?)	
Have you ever seen any health professionals about your child's development? Y <input type="checkbox"/> N <input type="checkbox"/> (If yes, please list)	
Are they things that you need to help your child with that you would expect them to be doing by themselves? Y <input type="checkbox"/> N <input type="checkbox"/> (If yes, please list)	

What do you think your child is good at?

Medical

Does your child have any ongoing health concerns? Y ☐ N ☐ (If yes, please list)

Is your child currently taking any medication? Y ☐ N ☐ (If yes, please give details)

Has your child needed to go to hospital? Y ☐ N ☐ (If yes, please give details including which hospital)

How would you describe your child's sleep?

Do they have any difficulties with eating? Y ☐ N ☐ (If yes, please describe)

Other

Do you have any other concerns for your child? Y ☐ N ☐ (If yes, please list)

What do you hope to get out of a PATCHES Neurodevelopmental assessment?

With written consent from the patient's legal guardian (see following page), PATCHES Paediatrics may gather additional information from a range of sources including:

- The patient's school teacher.
- The patient's carer.
- Medical records including birth records, paediatric reports, and allied health reports.

To assist us in this process, please ensure that you have provided the contact details of the relevant individuals and services in the appropriate places on this form.

Parent/Guardian Consent

Your consent gives permission for your child (the patient) to be seen by the PATCHES Paediatrics team until your child is "discharged from the service". You may formally withdraw your consent at any time.

Please ✓ to indicate consent

I give my consent for PATCHES Paediatrics to:

- ☐ Undertake assessments and therapy interventions at any site, including schools and clinics
- ☐ Obtain, release and exchange reports and relevant information (both written and verbally) with other agencies and individuals as required including:
 - The patient's school, including school Psychologist service reports
 - The patient's nominated GP
 - Aboriginal Medical Services
 - Any relevant Medical or other Child Development Services
- ☐ Make audio and/or visual recordings of my child for assessment, management and therapy purposes
- ☐ I understand that PATCHES Paediatrics is obliged to release relevant information to the Department of Child Protection pertaining to patients in care
- ☐ I understand PATCHES will not administer any medication to my child
- ☐ Research at PATCHES:
 - As well as using the information we collect about your child for their clinical care, we also use it for research and evaluation purposes. For example, we might use your child's data for annual reports about our service, to look at ways we can improve our service, conference presentations and/or research publications.
 - Whenever we present information, we do it so that identifying information is not included and you or your child cannot be identified e.g. we do not use your child's name.
 - We sometimes work with researchers from outside our clinic. The research we do is approved by a Human Research Ethics Committee and tends to look at groups of people rather than just one person (e.g., what was the average age of our clients).
 - While there are no *direct* benefits to you or your child from letting PATCHES use your child's information for research, this information might help us improve our understanding and treatment of various psychological and medical conditions, potentially benefiting future patients.
 - It is ok if you do not want your child's information used for research purposes.
 - You can change your mind at any time **after** signing this Consent Form.

Confidentiality

All medical records are stored securely. Only PATCHES staff members have access to these records, unless the law requires us to disclose it.

- Consistent with WA Health policy and legal standards, all medical records are kept for a minimum of 7 years after the death of a patient and then destroyed
- Your child's information will be used as described in this form and not otherwise disclosed (unless disclosure is required by law).

If you have any questions, we can talk to you before you sign this consent form.

- I have read and understood the information provided above. Any questions that I have asked have been answered to my satisfaction.
- I understand that if I have further questions or I wish to withdraw my consent at a later date, I may contact PATCHES on (08) 6280 1259.
- I give my permission for PATCHES to enter my child's information into a database with the understanding that any information used for reports, conference presentations and/or research publications will be de-identified.
- I understand that the information I provide will be kept in the strictest confidence by PATCHES, unless obliged to release by law.
- I understand that, if I wish, I may ask for a copy of this Information and Consent Form.

Name of Child/Client _____

Legal Guardian Name _____

Legal Guardian Signature _____ Date ____/____/20____