PATCHES Paediatrics – 10 Leura St, Nedlands WA 6009
diagnosis@patches-paediatrics.com.au
Perth Tel: 08 6280 1259 Kimberley Region Tel: 0409 040 597 Fax: 08 6208 3202
www.patches-paediatrics.com.au

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-paediatrics.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: ☐ Male	☐ Female ☐ Other
ATSI Status	☐ Aboriginal ☐Torres Strait Islander ☐Both ☐Neither		
Preferred Spoken Language			
CRN			

Parent/Carer Name		Ph:	
Relationship to Patient		ATSI Status: ☐Aboriginal ☐TSI ☐Both ☐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 ☐ FASD ☐ Global Developmental Delay ☐ Autism ☐ Other:

Patient in care of Child Protection & Family Support	Y☐ N ☐	Case Worker:	
Contact Details	Email:	Ph:	

Patient known to Disability Services Commission	Y☐ N ☐	Local Coordinator:	
Contact Details	Email:	Ph:	

Patient known to Child Development Services		Y☐ N ☐	Service:
Contact Details	Email:		Ph:

Patient known to Aboriginal Health Service		Y☐ N ☐	Service:
Contact Details	Email:		Ph:

Patient known to Corrective Services		Y☐ N ☐	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☐ N ☐	If No, Approximate Attendance: _____ %	
Academic Performance at school compared to peers:			
Are there concerns with attention and/or hyperactivity at school? Y☐ N ☐ (if yes, please describe)			
Are there concerns with social functioning at school? Y☐ N ☐ (if yes, please describe)			
Are there concerns with emotional functioning at school? Y☐ N ☐ (if yes, please describe)			
Are there other concerns at school? Y☐ N ☐ (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☐ N ☐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☐ N ☐If yes – Service(s): Contact Details:

Were there any concerns during the pregnancy with your child? Y☐ N ☐ (If yes, please list)
Did the child's mother use alcohol or other drugs during pregnancy? Y☐ N ☐ (If yes, please give details)
Was your child born to full term? Y☐ N ☐ At how many weeks' gestation were they born?
Did your child have any health concerns at birth or before their first birthday? Y☐ N ☐ (If yes, please list)
Did you ever have any concerns about your child's development? Y☐ N ☐ (If yes, what were you concerned about?)
Have you ever seen any health professionals about your child's development? Y☐ N ☐ (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☐ N ☐ (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?
How did you hear about PATCHES Paediatrics?

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.

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___

