**Referral Form**

Client name……………………………………………………………………….

Male or Female Child or Adult

DOB……………………………………………………………………………....

Caregiver …………………………………………………………………………

Support Worker…………………………………………………………………...

School…………………………………………………………………………….

Email……………………………………………………………………………...

Address…………………………………………………………………………...

Mobile…………………………………………………………………………….

Do you require wheelchair access? Yes or No

**Payment options** please indicate

**Private Counselling** Y/NRebates: BUPA/Medibank/Police & Nurses fund

**NDIS number**……………………………….. NDIS: Agency or Self- Managed

Plan Manager email address required for Agency managed clients ……………………………………………………………………………………

Do you or your child have a Positive Behaviour Management Plan? Y/N

**Therapy service required** please comment

Disability: Please state diagnosis…………………………………………………

Early Intervention (Bridie specialises in Speech delay ages 3-7)

……………………………………………………………………………………

Autism (Emotional regulation & social skill issues for children under age 13)

……………………………………………………………………………………

Counselling (General, Children or Trauma Informed Counselling)

……………………………………………………………………...…………….……………………………………………………………………………………

Mental illness: Please state diagnosis…………………………………………….

Group Music Therapy: Child or Adult