Referral to early childhood partners

Please use this form when seeking support through the National Disability Insurance Scheme (NDIS) for a child who lives in either Central Highlands (Ararat, Ballarat, Golden Plains, Hepburn, Moorabool, Pyrenee) or Wimmera South West (Corangamite, Glenelg, Hindmarsh, Horsham, Moyne, Northern Grampians, Southern Grampians, Warrnambool, West Wimmera, Yarriambiack) to record information about a child younger than 6, when there are concerns with their development, or a child younger than 9 with a disability.

# What is the early childhood approach?

The National Disability Insurance Scheme (NDIS) early childhood approach is a family-centred, holistic, and best practice approach to early intervention for children younger than 9 with disability or children younger than 6 with developmental delay or concerns. This approach is designed to provide children and their families with the support they need to achieve their goals and reach their full potential. If you believe a child younger than 9 may benefit from this support, you can make a referral.

# The early childhood partner’s role

Early childhood partners are a contact point for families and carers of children younger than 9, seeking support through the NDIS. They help to determine the most appropriate supports for the child and family, tailored to their individual needs and circumstances.

The types of supports provided by an early childhood partner may include connections:

* with mainstream and community services
* to practical information relevant to a child’s development
* with other families
* with early supports
* to apply to the NDIS

# How to complete and submit this form

This form may be completed by:

* a family or carer, with the assistance of a professional
* a professional working with the family or carer such as a GP, paediatrician

There are three steps to complete and lodge this form**:**

1. Complete the referral to early childhood partner form and record parent, carer, guardian or child representative consent.
2. If consent is provided by the parent, carer, guardian, please attach copies of any relevant assessments, reports or letters from health professionals that describe the child’s needs in support of this information form where appropriate.
3. Return the completed information form and any attachments to:

**Central Highlands EC:**

* Email: ECEI.LINK.LCHS@ndis.gov.au
* Mail: PO Box 279, Ballarat VIC 3353
* In person: Lvl 2, Central Square Shopping Centre,

 18 Armstrong St South, Ballarat VIC 3350

**Wimmera South West EC:**

* Email: ECEI.LINK.LCHS@ndis.gov.au
* Mail: 1 / 607 Canterbury Road, Vermont VIC 3133
* In person: 48 Kepler St, Warrnambool VIC 3280

 142 Firebrace St, Horsham VIC 3400

# Do you need more information?

* Online: Further information can be found at the NDIS website ([ndis.gov.au](http://www.ndis.gov.au))
* Phone: 1800 546 532

# Referral to early childhood partners

## Child’s details

| Child’s details required | Please complete all sections below |
| --- | --- |
| Child’s full name: | Click or tap here to enter text. |
| Date of Birth DD/MM/YYYY: | Click or tap here to enter text. |
| Aboriginal or Torres Strait Islander?  | Click or tap here to enter text. |
| Country of birth: | Click or tap here to enter text. |
| Is the child an Australian Citizen? | Yes |[ ]
|  | No |[ ]
| If No, does the child hold: | A Permanent Residency Visa: [ ]  Yes [ ]  NoProtected Special Category Visa holder: [ ]  Yes [ ]  NoOther type of visa? Please specify:  Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Number: \_\_\_\_\_\_\_\_\_\_\_ |
| Who does the child live with? | Click or tap here to enter text. |
| Home address: |  |

## Family or carer details

| Family or carer 1 details | Please complete all sections below |
| --- | --- |
| Family or carer 1 full name: | Click or tap here to enter text. |
| Relationship to child? | Parent |[ ]
|  | Carer |[ ]
|  | Guardian |[ ]
| Home address: | Click or tap here to enter text. |
| Contact number: | Click or tap here to enter text. |
| Email: | Click or tap here to enter text. |
| Preferred contact method: | Click or tap here to enter text. |
| Preferred language: | Click or tap here to enter text. |

|  |  |
| --- | --- |
| Family or carer 2 details | Please complete all sections below |
| Family or carer 2 full name: | Click or tap here to enter text. |
| Relationship to child? | Parent |[ ]
|  | Carer |[ ]
|  | Guardian |[ ]
| Home address: | Click or tap here to enter text. |
| Contact number: | Click or tap here to enter text. |
| Email: | Click or tap here to enter text. |
| Preferred contact method: | Click or tap here to enter text. |
| Preferred language: | Click or tap here to enter text. |

## Additional details

| Documentation details | Please complete all sections below |
| --- | --- |
| Custody or court ordersIs there an existing parenting, custody or guardianship arrangement for the child?If ‘yes’ please attach them to this form when submitting it. | Click or tap here to enter text. |
| Has your child had any assessments or diagnoses?If yes, please provide details or attach reports. | Click or tap here to enter text. |
| Is your child undergoing assessment for developmental delay or disability? | Yes |[ ]
|  | No |[ ]
| Additional information (for example: recent hospitalisation, starting school soon etc.) | Click or tap here to enter text. |

## Other services in place or previously accessed

| Service 1 details | Please complete all sections below |
| --- | --- |
| Name**:** | Click or tap here to enter text. |
| Profession**:** | Click or tap here to enter text. |
| Contact details(including organisation name): | Click or tap here to enter text. |
| Consent**:**Does the parent, carer or guardian give permission for us, the early childhood partner, to contact the above listed professional or service provider and share the child’s information to better understand their circumstances? | Yes |[ ]
|  | No |[ ]

| Service 2 details | Please complete all sections below |
| --- | --- |
| Name**:** | Click or tap here to enter text. |
| Profession**:** | Click or tap here to enter text. |
| Contact details(including organisation name): | Click or tap here to enter text. |
| Consent**:**Does the parent or carer or guardian or give permission for us Latrobe Community Health Services, to contact the above listed professional or service provider and share the child’s information to better understand their circumstances? | Yes |[ ]
|  | No |[ ]

## Current concerns in areas of major life activity

| Areas of major life activity | Provide details below orattach any relevant reports. |
| --- | --- |
| Self-Care**:**For example, how they bathe, dress themselves, eat, drink, use the toilet and sleep. | Click or tap here to enter text. |
| Receptive and Expressive Language**:**For example, how they understand words, including through gestures and signs. It’s also about how they communicate with you. This could be through facial expressions, gestures or verbal words. | Click or tap here to enter text. |
| **Cognitive Development:**For example, how they understand and remember information, learn new things, practice and use new skills, play with others, develop social and safety skills and problem solve. | Click or tap here to enter text. |
| Motor Development**:** For example, how they move around their home and community such as walking, running and crawling. It could also include information about how they pick up and use their hands to play with different objects. | Click or tap here to enter text. |

# Referrer details

Note**:** Please only complete this section if the referrer is an organisation.

If you are a **p**arent, carer or guardian of the child, please go to [parent or carer](#_Parent_/_Carer) consent section on the next page.

| Referrer details | Please complete all sections below |
| --- | --- |
| Date DD/MM/YYYY: | Click or tap here to enter text. |
| Organisation making referral: | Click or tap here to enter text. |
| Contact person: | Click or tap here to enter text. |
| Phone number: | Click or tap here to enter text. |
| Email address: | Click or tap here to enter text. |
| Office address: | Click or tap here to enter text. |

Note**:** The early childhood partner may need to contact the professional listed above to better understand the child’s circumstances and to ensure that the child is connected to the supports that best meets their needs.

|  |
| --- |
| Consent to contact the professional referrer is provided |
| Yes |[ ]
| No |[ ]

# Parent or carer consent

|  |
| --- |
| By signing this form |
| * I have read and understood the General Information and the Important Privacy Information provided with this information form.
 |[ ]
| * I understand how my child’s personal information will be collected, used and disclosed for the purposes of the NDIS, which is set out below in Privacy Policy.
 |[ ]
| * I have carefully read all of the information provided in the referral form and confirm that it is accurate, complete and up to date.
 |[ ]
| * I consent to Latrobe Community Health Servies collecting, using and disclosing personal and sensitive information about my child in accordance with the General Information and Important Privacy Information sections in this document.
 |[ ]
| * I understand that I may withdraw consent to receive support from an early childhood partner at any time.
 |[ ]
| * I give permission to contact the professional completing or assisting with this information form (if any).
 |[ ]

Please complete your details on the next page**.**

|  |
| --- |
| Parent or carer’s details |
| Signature: | Click or tap here to enter text. |
| Name: | Click or tap here to enter text. |
| Please tick your relationship to the child: | Parent | [ ]  |
|  | Carer | [ ]  |
|  | Guardian |[ ]
|  | Professional referring childIf so, please confirm that you have received verbal consent from the child’s parent, carer or guardian to make this referral | [ ] Consent:[ ]  |
| Date: DD/MM/YYYY | Click or tap here to enter text. |

# Privacy Policy

<https://www.lchs.com.au/privacy>