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| Email – [admin@promoteot.com.au](mailto:admin@promoteot.com.au)  Phone – 07 48314610  Fax – 07 48314602  Mob - 0469820723 |  |

# REferRal FORM

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| |  |  | | --- | --- | | Referred By - | Designation - | | Phone Number - | Date - |  Client INFORMATION  |  |  |  |  | | --- | --- | --- | --- | | Child’s name: | | | | | Birth date: | Age: | Sex: | Grade |   Parent’s Names –  Address (Residential) –  Address (Postal, if different) –  Email address –  Phone No. – Mobile no. –  School/Pre-school/Day-care -  Address-  Contact person- Contact number-  E-mail - INSURANCE /FUNDING INFORMATION Please indicate primary mode of payment – Private / Medicare EPC plan/ Better start plan/ Helping children with Autism Plan/GP mental Health plan  Preferred mode of payment – Cash/Cheque/Internet transfers Reason for referral Concerns regarding   |  |  |  |  |  | | --- | --- | --- | --- | --- | | * Self-care | * Gross motor skills | * Behaviour | | * Play | | * Feeding | * Fine motor skills | * Sensory Processing | | * Organization | | * Toileting | * Handwriting | * Social skills | | * Balance / Coordination | | * Attention | | | * Low Self Confidence | | |  |