PLC LIGHTHOUSE
I NSPIRING LIFELONG WELLBEING

Occupational Therapy and Speech Pathology Referral Form

Please complete and return to child's classroom teacher or LEC team member.

Please tick either

Occupational Therapy ☐ Speech Pathology ☐

CHILD'S NAME			
DATE OF BIRTH		MALE | FEMALE [PLEASE CIRCLE]	
YEAR LEVEL		TEACHER'S NAME	
ALLERGIES OR MEDICATION			
DEVELOPMENTAL HISTORY			
REASON FOR REFERRAL OR CONCERNS			
HEALTH INSURANCE PROVIDER			

PARENT/CAREGIVER'S NAME/S		
ADDRESS		
TELEPHONE	HM:	HM:
	MOB:	MOB:
EMAIL		
PREFERRED TIMES/ CONTACT ARRANGEMENTS		

☐ I consent for my therapist to communicate with allied health professionals and School staff about my child's assessment and any ongoing intervention.

On receipt of this referral, the therapist will contact parents to discuss the referral and advise about the payment process and any frequently asked questions.

SIGNATURE: DATE

DOVE OCCUPATIONAL THERAPY TEAM
125A BROADWAY AVE NEDLANDS WA
T: (08) 9389 7719 | E: INFO@OTDOVE.COM.AU

FREMANTLE SPEECH PATHOLOGY SERVICES
1/14 COCKBURN ROAD HAMILTON HILL WA
T: (08) 9433 4595 | E: RECEPTION@FREOSPEECH.COM.AU