ECEI can offer a range of supports for families with a child aged 0 to 6 years who has either a disability or a developmental delay. The type of supports offered will be different for every child and their family according to their individual needs.



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| --- |
| Child details |
| First name |  | Last name |  |
| Date of birth |  |  | Gender: |  |  |
| Home address |  |
| Does the child identify as Aboriginal and/or Torres Strait Islander? | Yes |  | No |  |
| Does the child live with their parents? | Yes |  | No |  |
| If no, please provide details of living arrangements: |  |
| Is the child an Australian citizen? | Yes |  | No |  |
| If the child is not an Australian citizen, do they hold: |
| * a permanent visa or are protected by Special Category Visa holder?
 | Yes |  | No |  |
| * another type of visa (please specify, eg Bridging Visa, Temporary Protection Visa, Protection Visa):
 |
| Parent / carer details |
| **Adult 1**: Name |  |
| Relationship to child: |  | Preferred language |  |
| Does this person identify as Aboriginal or Torres Strait Islander? | Yes |  | No |  |
| Email address |  |
| Phone number |  | Preferred contact | Phone |  | Email |  | Post |  |
| **Adult 2**: Name |  |
| Relationship to child: |  | Preferred language |  |
| Does this person identify as Aboriginal or Torres strait Islander? | Yes |  | No |  |
| Email address |  |
| Phone number |  | Preferred contact | Phone |  | Email |  | Post |  |
| Custody / court orders |
| Are there any court orders / custody arrangements for the child? | Yes |  | No |  |
| *If yes, please provide a copy of the court order with this application*  |
| Language |
| Main language spoken at home: |  |
| Is an interpreter required for the phone conversation? | Yes |  | No |  |
| Professionals / services currently involvedPlease list the services and supports you are already using to help you meet your child’s needs (e.g. GP, paediatrician, maternal & child health nurse, medical specialist, therapist, etc.) and the services your child currently attends (e.g. childcare, kindergarten, occasional care, etc.) |
| Service name |  | Profession |  |
| Address |  | Phone |  |
| Has the family given ECEI permission to contact and share information? | Yes |  | No |  |
| Service name |  | Profession |  |
| Address |  | Phone |  |
| Has the family given ECEI permission to contact and share information? | Yes |  | No |  |
| Service name |  | Profession |  |
| Address |  | Phone |  |
| Has the family given ECEI permission to contact and share information? | Yes |  | No |  |
| Service name |  | Profession |  |
| Address |  | Phone |  |
| Has the family given ECEI permission to contact and share information? | Yes |  | No |  |
| Child’s disability and / or developmental delay |
| Does the child have a diagnosed disability? | Yes |  | No |  |
| If yes, please indicate the diagnosis |  |
| *If no, is the child undergoing assessment for disability or developmental delay* | Yes |  | No |  |
| Has the child had a recent developmental screen with the Maternal Health Service? | Yes |  | No |  |
| If yes, was referral to ECEI recommended? | Yes |  | No |  |
| Has the child had a vision assessment? *If yes, please attach report* | Yes |  | No |  |
| Has the child had a hearing assessment? *If yes, please attach report* | Yes |  | No |  |

|  |  |
| --- | --- |
| Developmental Area | Concerns*Describe the concerns regarding the child’s development* |
| **Self-care** *(eg feeding / dressing / toileting etc. appropriate for age)* |  |
| **Physical skills***(eg gross and fine motor skills such as moving around / crawling / walking / sitting, rolling, using mobility aids etc.)* |  |
| **Communication** *(eg understanding, talking and communicating needs with others appropriate for age, etc.)* |  |
| **Relationships and behaviour** *(eg relating to others within the home or community environments etc.)* |  |
| **Learning and play** *(eg learning, remembering and practicing new skills such as playing games, pretend play, etc.)* |  |

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| Consent to provide information |
| As the parent or carer of this child, I give consent for this information to be provided to Merri Health. |
| Parent / Carer Name |  |
| Signature |  | Date |  |
| Name of person providing support to complete this form: (if applicable) |
|  |
| Position: |  | Organisation: |  |

Please forward to Merri Health Intake via email ecei@merrihealth.org.au

Need more information? Ph: 1300 665 437 (1300 OM KIDS)

Office use only – date referral received: