**Client Referral Form – Music Therapy**

**Client Details** (where known)

|  |  |  |  |
| --- | --- | --- | --- |
| **Client Name:** |       | **Date of Birth:** |       |
| **Contact Phone Number:** |       | **Email Address:** |       |
| **Address:** |       |
| **Next of Kin / Client Representative Name:** |       | **Relationship to Client:** |       |
| **NOK Contact Number:** |       | **NOK Email Address:** |       |
| **Tick all that apply:** (if known) | [ ]  NDIS self-managed [ ]  NDIA managed[ ]  NDIS plan-managed [ ]  Private / self-funded[ ]  Home Care Package (HCP) [ ]  Organisation funded[ ]  AN-ACC funded  |
| **NDIS details:**(where applicable) | NDIS number: |       |
| Current plan end date: |       |
| Plan manager accounts email: |       |

**Referral Details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Referrer Name:** |       | **Profession:** |       |
| **Contact Phone Number:** |       | **Email Address:** |       |
| **Please briefly outline the client’s medical history / status (you may also use the relevant tick boxes):** |
|      [ ]  Cancer [ ]  Palliative care [ ]  Anxiety[ ]  Depression [ ]  Other mental illness [ ]  PTSD / trauma[ ]  Younger onset dementia. [ ]  Dementia [ ]  Parkinson’s[ ]  Multiple Sclerosis [ ]  Huntington’s [ ]  Stoke survivor[ ]  Acquired / traumatic brain injury (ABI/TBI) [ ]  Spinal Cord injury (SCI)[ ]  Autism [ ]  Other; please specify:  |
| **Please outline reasons for referral to music therapy:** |
|  |
| ***Please identify the domains relevant to this referral:*** |
| [ ]  **Psychosocial & Emotional** *(self-expression, emotional awareness and regulation, self-concept & identity, confidence & empowerment, legacy & life review, stress, belonging, relational)*  | [ ]  **Behaviour** *(managing angry and frustration, mood regulation, positive behavior planning)*  |
| [ ]  **Cognitive** *(memory, attention, planning, self-monitoring, initiation, motivation, arousal)* | [ ]  **Mental Health** *(depression, anxiety, trauma, stigmatization, isolation, mental illness)*  |
| [ ]  **Communication** *(expressive language, speech articulation, managing stuttering, non verbal and social communication)* | [ ]  Other; please specify: |
| [ ]  **Physical** *(gross and fine motor function, coordination, balance, mobility and gait, pain, respiratory function)*  |
| **How frequently would you like music therapy?** *(if known)* |
| [ ]  weekly [ ]  fortnightly [ ]  not sure |
| ***Please indicate your preferred days/times for music therapy?*** *(if known)* |
| *Monday:* [ ]  morning [ ]  afternoon *Tuesday:* [ ]  morning [ ]  afternoon *Wednesday:* [ ]  morning [ ]  afternoon *Thursday:* [ ]  morning [ ]  afternoon *Friday:* [ ]  morning [ ]  afternoon ***If we have a timeslot available that does not align with your indicated preferences, would you like to be contacted?*** [ ]  Yes [ ]  No |

**Thank you for taking the time to complete this referral form. Please send you completed form to** **info@attunedhealth.com.au****.**

**We will review this information and contact the client to discuss and arrange services.**