**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**](mailto:info@attunedhealth.com.au)**.**

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