Government of South Australia
SA Health

Southern Adelaide Local Health Network

CHILDREN'S ASSESSMENT TEAM REFERRAL

(MR606)

Site: .....

Affix patient identification label in this box

UR No: .....

Surname: .....

Given Name: .....

Second Given Name: .....

D.O.B: ..... Sex: .....

Children's Assessment Team
Level 2 GP Plus Marion
10 Milham Street, Oaklands Park SA 5046

Tel: (08) 7425 8466 Email: health.cat@sa.gov.au

Referrals will only be accepted via email from Medical and/or Allied Health Professionals. This form is not to be completed by family/carer.

The Children's Assessment Team (*CAT*) is a ***neuro-developmental assessment service*** for children and young people under the age of 15 living in the Southern Adelaide Metropolitan Region with complex developmental concerns in *three or more* domains/areas.

Please tick and describe with detailed clinical evidence three or more areas below

☐ Cognitive / Intellectual concerns (*e.g. slow learning, processing information, understanding basic concepts*)

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☐ Language problems (*e.g. use and understanding of language, not speech issues such as clarity or fluency)*

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☐ Fine motor problems (*e.g. hand writing, scissors manipulation, motor planning and dexterity)*

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☐ Gross motor problems (*e.g. balance, ball skills, coordination, muscle strength, motor planning, and endurance)*

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☐ Sensory processing difficulties impacting daily life

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.....

☐ Play and socialisation problems (*e.g. difficulty relating to peers, reduced play skills and nonverbal communication*)

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☐ Repetitive behaviours and play (*e.g. repetition, inflexible, routines, motor mannerisms)*

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☐ Highly focused interests

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☐ Selfcare (*e.g. delays or difficulties in dressing, toileting, feeding*)

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Form has dual purpose—Scan as
Referral **Out** –**Sending Referrer** Service
Referral **In** – (select Speciality) –**Receiving** Service/Clinic

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Exclusions *(Unless occurring as well as three areas above)*

CAT does not accept referrals for young people 15 years of age and older

CAT does not see children with a single area of concern, for example:

- Isolated learning difficulties
- Behavioural and emotional regulation issues, such as episodes of emotional dysregulation, oppositional or defiant behaviour, conduct concerns, physical aggression or violent behaviour, without other developmental concerns.
- Mental health concerns such as features of Anxiety, Depression without other developmental concerns
- Features of Attention Deficit Hyperactivity Disorder (*ADHD*) without other developmental concerns

Who can refer to CAT?

All referrals must be completed using this CAT Referral form - please address to healthcat@sa.gov.au

- Medical Practitioners (*General Practitioners, Paediatricians, Medical Officers, Specialists*)
- Allied Health Professionals

Please note that CAT does not provide second opinions or review assessments for funding purposes (ie NDIS), when a child has an existing diagnosis that explains their difficulties.

Referral Acceptance

Our service uses *Personify Care* to manage referrals as a secure platform for communicating with children and young people's families/carers. Referrers must provide a contact email address for the child's carer to allow CAT to contact them.

All referrals go through a triage process prior to being accepted. To decide on eligibility, additional information may be requested. The referrer and the family/carer, will be advised whether the referral has been accepted via email, letter or secure communication via Personify Care.

Please note that there are extended wait times for this service. Please arrange therapy and support for the child while they wait for an assessment. If accepted, our service will usually contact the family / carer with an appointment 1—2 months ahead of time.

Catchment Areas

The Children's Assessment Team only accepts referrals for children who live in our catchment area. Please see map at the end of the form.

Note to Referrers

When the information in a CAT referral form indicates that the SALHN General Paediatric Outpatient Service will be a more appropriate service for a child, CAT will contact the referrer to request a separate referral to that service, and the CAT referral will be closed. Families will be notified of this by email.

Referrers and families will be notified by email if this has occurred.

The family can decline this service.

Please be aware the information in this form will be uploaded to the SA Health Electronic Medical Record system (EMR). This will be available for all SA Health staff involved in the child's care. This may also be subject to Freedom of Information requests.

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****MEDICAL PROFESSIONALS ONLY TO COMPLETE****

Dear DR ☐ GALLUS ☐ CHAN ☐ DAVIS

*All information must be provided for the referral to be processed.

CHILD *

Name: _____ *Surname* _____ *Given Names*

Date of Birth: _____ Sex: _____

Child's Address _____

Parents _____ *Parent 1** _____ *Parent 2**

Postal Address _____ _____

Residential Address _____ _____

Telephone _____ _____

Email Address *(This is required to process application)* _____ _____

Legal Guardian *(if other)* _____

Postal _____ Telephone _____

Residential _____ _____

Medicare No: *Include Child's ID No.* _____ Expiry Date: __ __ / __ __ / 20 __ __

☐ Yes ☐ No Is this child under Guardianship of the Chief Executive (*CE*)? *

If YES please provide name of Department for Child Protection Caseworker and Office

_____

REFERRER *

Name _____

Date of Referral _____

Agency & Position _____

Email Address *(This is required to process application)* _____

Address _____

Telephone _____

DOCTORS ONLY: **Provider No *:** **Referral Length:** ☐ 12 Months ☐ Indefinite

☐ Yes ☐ No	Does the child identify as Aboriginal / Torres Straight Islander? *
☐ Yes ☐ No	If under Guardianship of the Minister, has the child had an initial medical assessment?
☐ Yes ☐ No	Has the child had a Comprehensive Health and Development Assessment (*under Guardianship only*)?
☐ Yes ☐ No	Is there a Family Court Order in place? * *If yes, a copy is required as part of referral.*
☐ Yes ☐ No ☐ N/A	If the parents are separated, are both parents aware of the referral to CAT? *
☐ Yes ☐ No	Do both parents consent to the referral?
☐ Yes ☐ No	Is an Interpreter required? * *If yes, which language:* _____
☐ Yes ☐ No ☐ Unsure	Has the child been referred to the National Disability Insurance Scheme (*NDIS*)*?
☐ Yes ☐ No ☐ Unsure	Is the child receiving NDIS services? *

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Reason for Referral to CAT

Are there questions around

ASD ☐ **GEN. DEV.** ☐ **FASD** ☐ *(PAEDIATRICIANS ONLY)*
PLEASE PROVIDE INFORMATION REGARDING CONFIRMATION OF ALCOHOL USE

In addition to the concerns outlined on the first page, is there any additional information you would like to provide? Are there any psycho-social concerns (*e.g. trauma, vulnerabilities, parent mental health*) or general health concerns that need to be considered (*e.g. diet, sleep, attention*)?

Details of previous assessments and diagnoses, if available. Please include clinic letters:
(e.g. Psychology, Speech Pathology, Physiotherapy, Occupational Therapy, Medical/Paediatrics) - please attach copies of these reports where possible

Please use black ballpoint pen when completing this form

ASSESSMENT UNIT / TEAM CATCHMENT AREAS