678 High Street Thornbury 3071
630 Bell Street Preston West 3072
Phone: **9484 6299**
Fax: 9480 0838
e: admin@crisalida.com.au
w: www.crisalida.com.au

2B – Registration Form (Child)

To complete this form digitally, download file, open and fill in, select PRINT and change the printer to SAVE AS PDF

Child's Details

Name: DOB: Gender:

Language/s Spoken at Home:

Home Address:

Family/Contact Information

(in cases with separated parents, we do require consent from both parents/guardians in order to provide therapy)

Parent/Guardian 1:	Parent/Guardian 2:
Phone:	Phone:
Email:	Email:
Relationship to Child:	Relationship to Child:

Siblings (Names & Ages):

Referrer Information

Referrer Name:

Referrer Address:

Phone: Fax: Email:

FUNDING: ☐ Private Health | ☐ Mental Health Care Plan | ☐ Enhanced Primary Care Plan
☐ NDIS (Self Managed) | ☐ NDIS (NDIA Managed*) | ☐ NDIS (Plan Managed) | ☐ FAHCSIA | ☐ None

**Please note for NDIA Managed participants, we are restricted to only provide services under the 'Improved Daily Living' category and require a copy of the client's NDIS plan with this registration form.*

Family History: (eg. moves in residence, migration, significant family events, family history of disability, family relationships, illness)

MEDICAL HISTORY: (eg. pregnancy & birth details, current medications, significant illnesses, hospitalisations, accidents etc)

Hearing Problems: ☐ No | ☐ Yes (please explain):

Vision Problems: ☐ No | ☐ Yes (please explain):

Allergies:

DEVELOPMENTAL MILESTONES (please estimate ages when child could…)

Crawl:	Sit Alone:	Stand alone:
Walk alone:	Toilet trained:	Feed self:
Dress self:	Button/zips:	Single words:
Sentences:	Knife spreading:	Knife cutting:

Mostly Uses: ☐ Left Hand | ☐ Right Hand

Parent 1 Uses: ☐ Left Hand | ☐ Right Hand

Parent 2 Uses: ☐ Left Hand | ☐ Right Hand

EDUCATIONAL INFORMATION

School	Grade	Teacher

General Academic Performance (describe strengths/weaknesses):

Does your child have a teaching aide or any other special educational support:

☐ No | ☐ Yes, Name: ____________________ Phone: ______________________

MAIN CONCERNS please check box and explain below:

☐ Learning difficulties
☐ Gross motor
☐ Fine Motor
☐ Visual perceptual
☐ Cognitive Functioning
☐ Self-regulation
☐ Play
☐ Behaviour
☐ Speech/Language
☐ Eating
☐ Friendships
☐ Dressing
☐ Toileting
☐ Other

Please explain concerns: if there is not enough space, use additonal comments section or attach supporting documents.

What are your goals for this child:

Preferred Therapy: ☐ OT | ☐ PSYCH | ☐ SPEECH | ☐ ART | ☐ FAMILY | ☐ GROUP

Preferred Appointment Time: please tick (✓) all that apply

DAY	MON	TUES	WED	THURS	FRI	SAT
MORNING 8.30AM-12PM						
AFTERNOON 12-3PM						
AFTER SCHOOL 3-9PM						

Please note: afterschool and Saturday appointments are limited and may result in a longer wait period if this is your only availability

Additional Comments:

INFORMED CONSENT, CONFIDENTIALITY & RELEASE OF INFORMATION:

Please read the following statements regarding treatment, and sign to acknowledge you agree to these terms:

- As part of providing a service to you, we collect and record personal information from you that is relevant to your current situation. This information will be a necessary part of the assessment and treatment that is conducted.
- All personal information gathered by Crisalida during intake, assessment and/or therapy remains confidential and secure except in the following circumstances:
    - It is subpoenaed by a court
    - The therapist becomes aware of any risk to yourself or others
    - You agree to, and sign consent allowing, material to be retrieved/forwarded to a third party, such as a GP or other clinician for treatment/management purposes
- Routine practice requires written and at times verbal communication with your referring doctor (if applicable) and supervising clinicians within Crisalida.
- If you are referred under a Mental Health Care Plan through Medicare written communication with referring GP is mandatory after an initial six Medicare rebated sessions and any other subsequent sessions.
- Applicable fees are to be paid at each session unless otherwise negotiated with my treating therapist.
- In cases where there is a shared care arrangement or not formal custody arrangements for minors, both carers must consent to the child undergoing treatment or therapy services at Crisalida by signing this form
- This form must be signed before or at the first session in order for treatment or services to proceed. The patient cannot receive treatment or services unless this form has been completed
- So that therapists' time is utilised effectively, a cancellation fee to the value of 100% of the session fee applies if the client does not attend their appointment, or give more than 24 hours notice of non-attendance.

Please list any GP, Specialist, Occupational, Physical or Speech Therapist, Neurologist, Psychologist, Psychiatrist, Teacher etc that you would like your Crisalida therapist to communicate with:

Name: Occupation:
Address/Clinic:
Phone: Fax: Email:

Name: Occupation:
Address/Clinic:
Phone: Fax: Email:

Name: Occupation:
Address/Clinic:
Phone: Fax: Email:

Name: Occupation:
Address/Clinic:
Phone: Fax: Email:

Name: Occupation:
Address/Clinic:
Phone: Fax: Email:

Please tick: ☐ I consent to my therapist communicating within the Crisalida Therapy team

I have read the above informed consent, confidentiality, release of information and cancellation policies.

I am aware that cancellation fees are unable to be paid for by Medicare or FaHCSIA funding.

I consent to the parties listed to release and request information related to my history and treatment. I understand that this permission can be revoked at any time by myself in writing except for the information that has already been communicated.

I agree to the above conditions and to my self/child receiving clinical services at Crisalida Child, Adolescent and Family Therapy.

Child's Name: ______________________________

Parents and/or Guardians:

______________________________	______________________________
Full Name	Full Name
Address	Address
Phone Number	Phone Number
Signature Date	Signature Date

Once completed, please send to admin@crisalida.com.au with any relevant supporting documents if necessary.