Child Development Service, Western Bay of Plenty
112 Thirteenth Avenue, Tauranga 3112
Phone: (07) 571 4768
Fax: (07) 571 4778
email: cds.tauranga@bopdhb.govt.nz

BAY OF PLENTY DISTRICT HEALTH BOARD
HAUORA A TOI

Request for Support

CHILD DEVELOPMENT SERVICE, WESTERN BOP

Date of Referral:	**Forms with insufficient information will be returned**

Child and Family/Whānau Information	
Child's Name:	NHI Number:
Date of Birth:	Gender: ☐Male ☐Female
Carer Name(s)	Email:
Address:	Ethnicity/Iwi
Tel Number(s):	
Consent from family/whānau given for referral? ☐ Y ☐ N	Will an interpreter be required? ☐ Y ☐ N Language spoken at home:

Service Requested (Please provide details on page 2 to support request)	
☐ **VNT** (under 2.5 years)	☐ Gross Motor ☐ Sensory Issues ☐ Fine motor/play ☐ State Awareness/ Regulation issues ☐ ADLs (e.g. bathing, eating)
☐ **Occupational Therapy**	☐ ADLs ☐ Sensory needs ☐ Fine motor/play ☐ Equipment needs ☐ Housing ☐ Safety issue
☐ **Physiotherapy**	☐ Gross motor concerns/ delay ☐ Neuromuscular needs ☐ Equipment needs
☐ **Speech & Language Therapy** (Under 2 years of age) If older than 2 years: **Feeding**: refer Tga Hospital **Language**: refer to MOE	☐ Speech and language concerns/delays ☐ Delayed oromotor skills ☐ Frequent coughing/choking during intake ☐ Recurrent respiratory symptoms (possible aspiration pneumonia) ☐ Nil by mouth ☐ Tube fed ☐ Aversion/refusal to feeding
☐ **Dietitian** Weight: _____kg Length/Height: _____cm Head Circumference: _____cm Date of measure: _____	☐ Growth / Malnutrition ☐ Tube-feeding ☐ Food allergies / intolerance ☐ Nutritional deficiencies (please specify:_____) ☐ Other: _____
☐ **Psychology**	☐ **ASD assessment and formulation over 7 years**: please provide details to support referral, e.g. SRS forms (under 7 year please refer to ASD co-ordinator for MDAT) ☐ **Cognitive/Intellectual assessment and formulation** (incl. evidence of delay, e.g. results of school assessment)
☐ **Social Worker**	Please provide details on page 2
☐ **ASD Incredible Years**	Programme for parents

What are the families/whānau/carers priorities/concerns? (What specifically would the family/whānau like support with?)

Diagnosis/Clinical Information

Referrer's Details		
Full Name:		Agency and Postal Address:
Designation:		
Phone:		
Email:		

Other Agencies Involved (e.g. Paediatrician, Seating to Go, Family Start):		
GP:		
Preschool/School:		Ph:
ORS: ☐ Y ☐ N	Physical Disability Team: ☐ Y ☐ N	High Health Funding: ☐ Y ☐ N

Send Completed Referral to: Child Development Service, BOPDHB, Tauranga Hospital, Private Bag 12024, Tauranga 3143

Or email cds.tauranga@bopdhb.govt.nz