BAYNAV 1002 3/21

BAY OF PLENTY
DISTRICT HEALTH BOARD
HAUORA A TOI

REQUEST FOR SUPPORT
CHILD DEVELOPMENT SERVICE, EASTERN BOP

Forms with insufficient information will be returned

Date of Referral: ______________________________

CHILD AND FAMILY/WHĀNAU INFORMATION	
Child's name:	NHI number:
Date of birth:	Gender:
Carer name(s)	Email:
Address:	Ethnicity/Iwi:
Telephone number(s):	
Consent from family/whānau given for referral? ☐ Y ☐ N	Will an interpreter be required? ☐ Y ☐ N Language spoken at home:

WHAT WOULD WHANAU/FAMILY/CARERS OR YOURSELF LIKE SUPPORT WITH?

HEALTH HISTORY AND INFORMATION/DIAGNOSIS

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SERVICE REQUESTED Please indicate any of the following:

- ☐ Activities of Daily Living (ADL's)
- ☐ Fine Motor/play
- ☐ Housing Modifications
- ☐ Gross Motor concerns/physical delay
- ☐ Speech-Language concerns delays – <2yrs of age
- ☐ Alternative feeding e.g., tube
- ☐ Avoidance to feeding
- ☐ Nutritional deficiencies (please specify): ____________________
- ☐ Developmental Assessment
- ☐ Autistic Spectrum Disorder
- ☐ Carer Support
- ☐ Accessing Support Services
- ☐ Sensory needs
- ☐ Equipment needs
- ☐ Safety issue
- ☐ Co-ordination
- ☐ Feeding/drinking difficulties e.g., coughing, choking or chest infections
- ☐ Growth concerns
- ☐ Food allergies / intolerance: ____________________
- ☐ Cognitive/Intellectual assessment and formulation (incl. evidence of delay, e.g., results of school assessment)
- ☐ Social issues/support

ADDITIONAL INFORMATION

OTHER AGENCIES INVOLVED (e.g. Paediatrician, Seating to Go, Family Start)

GP:

Preschool/School: Ph:

Ministry of Education: ☐ Y ☐ N

Child Development Service may obtain information from other Agencies currently involved.

REFERRER DETAILS

Full name: ____________________ Designation: ____________________

Phone ____________________ Email: ____________________

Agency and postal address: ____________________

PRINT FORM | SUBMIT FORM TO CDS | CLEAR FORM