LIGHTHOUSE MUSIC THERAPY

REFERRAL FORM

PLEASE REFER THE COMPLETED FORM TO LIGHTHOUSE MUSIC THERAPY, 19A STEINISH, ISLE OF LEWIS, HS2 0AA OR EMAIL TO LIGHTHOUSEMUSICTHERAPY@GMAIL.COM

Client Information:

First name:

Surname:

Address:

Postcode:

Languages spoken at home:

Interpreter/Signer required? yes/no

GP name:

Address:

Telephone:

Preschool/School name:

Day/Times attended:

Address:

Keyworker/Headteacher:

Requires disabled access: yes/no

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Parent/Guardian Information

First name:

Surname:

Address:

Postcode:

Relationship to child:

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Referral Information

(If there is any information you feel would support this referral in providing information such as my world assessment or IEP and you are willing to share this information please attach to the back of this referral)

Diagnosis (if any/known): **Statemented:**

Are there any safeguarding issues?

Social services involvement: yes/no

Social Worker's name:

Contact number:

Are there any concerns about -
hearing? yes/no vision? yes/no

Has hearing been tested? yes/no
Date of hearing test:

Reasons for referral:

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What is the functional impact? Give details:

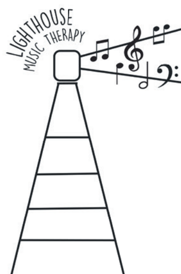
What support has already been provided? Give details:

If support has already been provided by a therapeutic agency have you attached any supporting information? yes/no

Has any other form of intervention made any difference to your child?

Other professionas/services currently involved (e.g. Educational psychologist/Occupational Therapist/Speech and Language Therapist)

Do you give permission for Lighthouse Music Therapy to make contact with these professionals to discuss any previous or ongoing work with your child: yes/no



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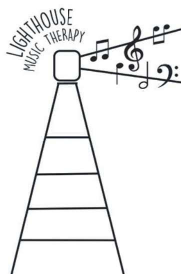
Referral and background information

Developmental and medical history information:

Does the child have any allergies or medical difficulties that the therapist should be aware of during sessions:



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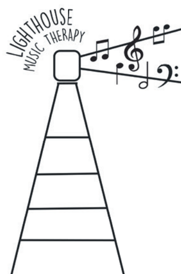
Developmental Information

Are there any concerns regarding the child's gross motor movement? Give details:

Are there any concerns regarding the child's fine motor movement? Give details:

Are there any concerns regarding the child's emotional state or development? Give details:

Are there any other concerns regarding the child's social behaviours and interactions? Give details:



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Interests and Social Interactions

Are there any other concerns regarding the child's social behaviours and interactions? Give details:

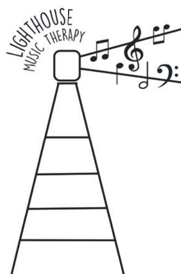
What types of games/toys/activities does the child enjoy?

Does the child engage in communication and interaction with other children?

Does the child engage in communication and interaction with adults?

Is the child verbal?

How would you describe the child's attention span for -
Activities of their own choice?
Activities that are chosen for them or tasks they are required to complete?



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Referrer Information

First name: **Date of referral:**

Surname:

Address:

Postcode:

Relationship to child:

Signature:

Parent/Guardian Consent

This referral has been discussed with me, and I agree to take my child to sessions in the agreed setting at an agreed time.

I agree to the sharing of information with services relevant to my child's treatment/care:

Name of parent/Guardian: **Signature:**

Date:

Therapist signature:
Date:
Location: