EMERALD MEDICAL GROUP

Allied Health Services | Paediatric Physiotherapy

Mr Woo Seok Che | Physiotherapist
1 Pilot Farm Road, PO Box 1844, Emerald QLD 4720
wseokche@chhealth.com.au

A. Referring School Details

School Name

School Address

Referee Name

Position

Phone

Email

B. Student & Parent / Guardian Details

STUDENT DETAILS

Full Name

Date of Birth

Year Level

Gender

Medicare No.

NDIS No.

PARENT / GUARDIAN DETAILS

Full Name

Relationship

Phone (Mobile)

Phone (Home)

Email

Preferred Contact: ☐ Phone ☐ Email ☐ SMS

C. Reason for Referral

Tick all that apply. Please provide additional context in Section D.

- ☐ Gross motor difficulty (running, jumping, balance)
- ☐ Fine motor difficulties (handwriting, coordination)
- ☐ Poor coordination / clumsiness
- ☐ Difficulty with sports / playground activities
- ☐ Reduced strength or endurance
- ☐ Other:
- ☐ Delayed motor milestones
- ☐ Attention / following instructions difficulties
- ☐ Sensory related difficulties
- ☐ Postural concerns

D. Observed Difficulties (Teacher Input)

Briefly describe concerns observed in the classroom, playground, and other school settings:

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E. Impact on Function / Participation

Tick all that apply:

- ☐ Difficulty keeping up with peers in physical activities
- ☐ Avoids physical activity / disengages from sport
- ☐ Struggles with classroom tasks (e.g. writing, sitting posture)
- ☐ Reduced confidence and participation in school activities
- ☐ Behavioural frustration linked to motor tasks
- ☐ Other:

F. Medical Background & Clinical History

Diagnosed Conditions (Optional — complete if known):

- ☐ ADHD
- ☐ ASD
- ☐ DCD (Developmental Coordination Disorder)
- ☐ Global Developmental Delay
- ☐ Not formally diagnosed
- ☐ Other:

Relevant Medical / Birth History: *Diagnosis, birth history, milestones, medications*

G. Previous / Current Supports

Tick all that apply:

- ☐ Occupational Therapy
- ☐ Learning Support / Teacher's Aide
- ☐ Physiotherapy
- ☐ None
- ☐ Speech Therapy
- ☐ Other:

H. Presenting Goals

Parent / Guardian Goal: *What do you most want to achieve from this assessment?*

School / Teacher Goal: *What outcome would best support this student in the school environment?*

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I. Consent & Declaration

By signing below, the referring person confirms that:

- ☐ Written parent/guardian consent has been obtained to refer this student to Emerald Medical Group.
- ☐ The parent/guardian has been informed that information in this form will be shared with the treating physiotherapist.
- ☐ All information provided is accurate and complete to the best of my knowledge.
- ☐ I understand this referral does not guarantee appointment availability. EMG will contact the parent/guardian directly.

Referring Person

Position

Signature

Date

J. EMG OFFICE USE ONLY — Do not complete below this line

Date Received

Received By

Appt Date

Appt Time

Parent Contacted: ☐ Yes ☐ No

Appointment Booked: ☐ Yes ☐ No

K. Notes / Flags

L. Appointment Details (EMG Office Use)

Appointment Date

Appointment Time

Clinician Assigned