## Influential Equine Therapy Intake/Referral form

**Information**

Participant Name/s: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred name/nickname:

Helper (Representative/Parent/Carer) Name/s: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Organisation or family representatives (please circle)

If organisation, please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Participant Date of Birth: \_\_\_\_\_\_\_\_ Participant age in years and months**: \_\_\_\_\_\_**

Gender of participant:  Male   Female

**If funded by NDIS please complete the below, if privately funded continue below this section:**

Participant’s NDIS number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ - **please attach a copy of NDIS goals**

Current NDIS Plan Dates:

NDIS Funding Type:  Self-Managed   Plan Managed

Name /Contact of Plan Manger (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Continue here:**

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Post Code: \_\_\_\_\_\_\_\_\_\_

Contact Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Contact Method:  Phone  Email

Emergency contact details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(name) Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Aboriginal/Torres Strait Islander?  Yes   No

Are there any cultural or religious sensitivities to which we should be aware?  Yes   No

If yes, details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary language in the home:  English    Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**General Developmental:**

Participants diagnosis/s’ (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the participant have any medical or health concerns we should be aware of?  Yes   No

Asthma    Allergies  Seizure    Seasonal Allergies

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the participant take any regular medications?  Yes   No

If yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How does the participant communicate? (i.e. verbal, point, words, visuals)

Example: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the participant have any specific concerns or behaviours you feel we should be aware of in planning for risk with this referral?  Yes   No

Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does participant understand simple directions? (e.g. “Put that down;”  “Take a step back.”)  Yes   No

**Support needs:**

Nonverbal    Verbal  Uses mobility supports    Hearing impaired

Visional impaired  Cognitive impaired    Utilises sign language  Utilises assistance animal    Utilises interpreter: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Greets people by:**

Verbal greeting    High five  Hand shake    Wave to say hello

Likely to not greet in any form  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **A bit about you and your goals** | | |
| To help us understand you better, please fill the below: | | |
| 💪 | My strengths are  (what I am good at)... |  |
| 👍 | I like... |  |
| 👎 | I don’t like…  (please include any sensory considerations) |  |
| 🙂 | You will know when I am happy by... |  |
| 😔 | You will know when I am unhappy by... |  |
| 💬 | I prefer to communicate by... |  |
| 🙂 | What are you wanting to achieve through Equine Therapy? (goals) |  |

**Session Preference:**

|  |  |  |
| --- | --- | --- |
| **Session** | **Session details** | **Tick sessions you are interested in**  **(make note of preferred session)** |
| Individual Session | 1:1 – please note: there is limited availability after school due to school-aged group sessions running during these times |  |
| Group session | Provider will group participants accordingly.  Minimum 4 participants to run a group session (max 5 ppl per group)  Group sessions will be available for:   * 5 and under * School-aged * Adults   School-aged sessions will be available and primarily reserved for after-school hours . |  |
| Private Group session  15% group discount | Group is pre-organised on referral (such as, school group, day service group, support coordinator oganised group).  Minimum 4 participants to run group session (max 5 ppl per group)  Group sessions will be available for:   * 5 and under * School-aged * Adults   School-aged sessions will be available and primarily reserved for after-school hours . |  |

**Preferred Days and Times**

Please tick the days and write the three most preferred times that would be suitable for your participant. Please understand that days and times are limited, and these can only be taken into consideration when scheduling.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Monday** | **Tuesday** | **Wednesday** | **Thursday** | **Friday** | **Saturday**  **(by special request)** | **Sunday**  **(by special request)** |
| **Times:**  **-**  **-**  **-** | **Times:**  **-**  **-**  **-** | **Times:**  **-**  **-**  **-** | **Times:**  **-**  **-**  **-** | **Times:**  **-**  **-**  **-** | **Times:**  **-**  **-**  **-** | **Times:**  **-**  **-**  **-** |

**Referrer Details (if applicable):**

|  |  |
| --- | --- |
| Name: |  |
| Contact Phone Number: |  |
| Contact Email: |  |
| Contact Address: |  |
| Contact details: |  |

**Consent Agreement**

I give permission for Influential Equine Therapy to use the information provided on this form to assist in identifying the participants needs.  I understand this also includes any preliminary evaluations/screens used to assess the participant.  I understand that this information will be kept completely confidential.  I am aware that I may request this information to be removed from the participants file if it is inaccurate, misleading or otherwise in violation of the privacy or other rights of the participant.  I am also aware that I may request a copy of this completed form for my own records.

|  |  |
| --- | --- |
| **By signing this form** | |
| * I have read and understood the General Information and the Consent information provided with this form. |  |
| * I have carefully read all of the information provided in the referral/intake form and confirm that it is accurate, complete and up to date. |  |
| * I consent to Influential Equine Therapy collecting, using and disclosing personal and sensitive information about the participant in accordance with the Consent Agreement. |  |
| * I understand that I may withdraw consent to receive support from Influential Equine Therapy at any time. |  |
| * I give permission to contact the professional completing / assisting with this information form (if any). |  |

|  |  |  |
| --- | --- | --- |
| **Participant or Representative details** **(person signing)** | | |
| Signature: |  | |
| Name: |  | |
| Please tick your relationship to the participant: | Parent |  |
| Carer |  |
| Guardian |  |
| Representative |  |
| Professional referring participant.  If so, please confirm that you have received verbal consent from the participant’s parent / carer / guardian / representative to make this referral | Consent: |
| Date: DD/MM/YYYY |  | |

**PLEASE RETURN ALL REFERALS TO INFLUENTIALEQUINETHERAPY@GMAIL.COM**