ACCIST
Cairns Catholic & Independent Schools Therapy
PO Box 5296 Cairns | (07) 40509722

Supported by funding through Special Disability Support in Schools (SDSS) program

Proudly supported by the Department of Education
Queensland Government

# CAIRNS CATHOLIC AND INDEPENDENT SCHOOLS THERAPY
# SDSS SCHOOL REQUEST FOR SUPPORT FORM

***Please complete all sections and return forms to: ewladmin@cns.catholic.edu.au***

| **SECTION 1: STUDENT DETAILS** | | | | |
|---|---|---|---|---|
| **Last name:** | | | **DOB:** | |
| **First name:** | | | **Age:** | |
| **Gender:** | | | | |
| **NCCD Category:** | □ **Cognitive** | □ **Sensory** | □ **Physical** | □ **Social Emotional** |
| **Level of Adjustment:** | □ **Supplementary** | □ **Substantial** | □ **Extensive** | |

| **SECTION 2: SCHOOL DETAILS** | | | |
|---|---|---|---|
| **School name:** | | **Class teacher:** | |
| **School suburb:** | | **Year level:** | |

| **SECTION 3: CASE MANAGER** | |
|---|---|
| **Name:** | |
| **E-mail address:** | |

| **SECTION 4: PARENT / GUARDIAN** | | | |
|---|---|---|---|
| **Name:** | | **Relationship to student:** | |
| **Address:** | | | |
| **Phone:** | | | |
| **E-mail address:** | | | |

| **SECTION 5: REASON FOR REQUEST FOR SUPPORT** | |
|---|---|
| **Primary Concerns:** | **Educational, Access & Participation Impacts:** |
| | |

| Please indicate the documents you have for this student that address the primary areas of concern: | | | |
|---|---|---|---|
| **Personal Learning Plan (PLP)** | □ **Yes** | | □ **Attached** |
| **Specialist report** (e.g. paediatrician, external therapy services, hospital) | □ **Yes** | □ **No** | □ **Attached** |
| **Other school-based documentation** | □ **Yes** | □ **No** | □ **Attached** |

## SECTION 5: SPECIALIST SERVICES

**Has the student been assessed by/received therapy from any of the following professionals?**
**Please attach relevant reports if available.**

| Specialist: | Name: | Assessment/therapy dates: | Report attached? | Consent to contact? |
|---|---|---|---|---|
| **Psychologist** | | | | |
| **Speech Pathologist** | | | | |
| **Occupational Therapist** | | | | |
| **Paediatrician** | | | | |
| **Physiotherapist** | | | | |
| **Other** | | | | |

## SECTION 6: HEALTH

| | | |
|---|---|---|
| **Has the student's hearing been checked?** | □ **Yes, date of test & results:** | □ **No** |
| **Has the student's vision been checked?** | □ **Yes, date of test & results:** | □ **No** |

## SECTION 7: SCHOOL CONSENT

**Please indicate your consent by ticking the box beside the statements below:**

- ☐ **I give permission for Cairns Catholic and Independent Schools Therapy (ACCIST) to provide services at our school, or as negotiated and agreed to by the above organisation and school.**
- ☐ **I understand that the SDSS services are to be provided in collaboration with the education professionals in the student's educational team.**
- ☐ **I understand that ACCIST will provide advice and support for the development and implementation of the student's Individualised Education Plan.**

Principal name:_____
(PLEASE PRINT)

Principal signature:_____

Date: _____

## PARENT / GUARDIAN CONSENT

**Please indicate your consent by ticking the box beside the statements below:**

- ☐ **I give consent for my child to receive therapy services from ACCIST as requested by the school. I understand that these services may include Speech Therapy, Occupational Therapy and Physiotherapy.**
- ☐ **I give consent for Therapists/Educators to discuss my child's learning needs with therapist from other support agencies (DET, Queensland Health, private therapists, external agencies).**
- ☐ **I give consent for _____ (*NAME OF SCHOOL*) to release information regarding my child to ACCIST. I understand that this may include reports from Occupational Therapy, Physiotherapy, Speech Therapy, Educator, IEP or School.**
- ☐ **I understand that information will be used by therapists to support my child's education and to complete the Support Data associated with funding requirements.**
- ☐ **I understand that assessment and/or follow-up services will be provided as required and appropriate, and that this may involve discussions with other agencies about my child.**
- ☐ **I give permission for a meeting regarding my child to proceed if I am unable to attend.**

**There are court orders / custody arrangements which apply to my child:**

☐ **Yes** | ☐ **No** | ☐ **Attached**

Parent/guardian name:_____
(PLEASE PRINT)

Parent/guardian signature: _____

Date: _____