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

Proudly supported by the Queensland Government
DELIVERING FOR QUEENSLAND | Queensland Government

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

Please complete all sections and return forms to: admin@accist.org.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: _____