Parent/Carer/Guardian Referral Form

PEBBLES: Continence Management Service for Children with Disabilities

PEBBLES is a state-wide program that provides support and management for children with toilet training and continence issues. It is funded by the Disability Services Commission of Western Australia and is managed by Therapy Focus in partnership with the Continence Advisory Service.

Separate referral forms are available for medical practitioners, allied health professionals and nurses.

Eligibility Criteria

- Child aged 0-16 years
- Child has Australian Permanent Residency status
- Child is eligible to receive disability services **or** is eligible for the Incontinent Pad Scheme (IPS)
- Child has toilet training or continence issues, including day wetting, constipation or faecal incontinence (soiling)
- Primary reason for continence issues must not be of a primary psychiatric disorder
- Continence or toilet training issues are included in the child's NDIA Plan

NB: Where bed wetting is the sole issue, referral will be made to a bed wetting clinic

Frequently Asked Questions

Q. My child does not receive services from Therapy Focus. Are they eligible for PEBBLES?

A. Yes, PEBBLES is a state-wide service for **all** children who meet the service eligibility criteria, not just those children receiving services from Therapy Focus.

Q Is there a fee for the service?

A. No, the service is free.

Q My child is on a waiting list for therapy services, can we still be referred to PEBBLES?

A. Yes, your child may still be eligible to be referred to PEBBLES. Please contact us if you would like any further clarification.

Q. Will PEBBLES provide a daily intensive toilet training program with my child?

A. No, PEBBLES provides strategies and tips to give parents/guardians skills and confidence to work on achieving toileting goals with their child. PEBBLES may suggest these strategies are shared with others involved in your child's care, and with your consent they can liaise with your child's school, day care centre, occupational therapist or other healthcare provider involved in your child's care.

About this Form

This form is for use by parents or guardians seeking referral to PEBBLES for their child. Therapy Focus is funded by the Disability Services Commission (DSC) to provide this service. We are required to release some information about people who use PEBBLES to the DSC. This information does not contain identifying details.

Please answer the questions by marking a tick (√) in the appropriate box.

If your child is receiving services from a disability services provider other than Therapy Focus, please sign the consent on page 6 so we are able to share information that confirms your child's eligibility to access this service.

What happens next?

Once your child's eligibility has been confirmed one of our friendly team members will be calling you within the next two weeks to ask you some more detailed questions about your child's bladder and bowel function. Following the phone call, we will be able to provide you with further information about when your child's appointment will be scheduled.

Client Name	First Name: _____ Family Name:_____
Date of Birth / /	**Gender** ☐ Female ☐ Male
Parent/Guardian/Carer Details *Office Use Only:* Region: _____	First Name: _____ Family Name:_____ Relationship to Child: _____ Address: _____ Phone No: _____ Mob No: _____ Email: _____ First Name: _____ Family Name:_____ Relationship to Child: _____ Address: _____ Phone No: _____ Mob No: _____ Email: _____
Does the child reside at the same address as the Parent/Guardian/Carer	☐ Yes ☐ No (please provide child's address details below) Address: _____ _____

Australian Permanent Residency Status (please provide proof of permanent residency e.g. copy of birth certificate, citizenship certificate, passport or visa as listed below)

- ☐ Australian Citizen (e.g. Australian birth certificate, a certificate of Australian citizenship)
- ☐ Australian Permanent Resident (e.g. a passport with a visa granting permanent residence or permanent entry stamp)
- ☐ New Zealand Citizen (e.g. special category visa subclass 444)
- ☐ Visa (Please provide a copy)

Proof of current address - please provide supporting documentation e.g., electricity bill, phone bill, car registration (if you have difficulty providing this information, please contact us, we may be able to assist)

What is the main language spoken at home?	
Is an interpreter required?	If YES please state language/dialect:
Is the child of	✓ **Tick ONE only**
Aboriginal but not Torres Strait Islander origin	☐
Torres Strait Islander but not Aboriginal origin	☐
Both Aboriginal and Torres Strait Islander origin	☐
Neither Aboriginal nor Torres Strait Islander origin	☐
Is the child is eligible for the Incontinent Pad Scheme (IPS)?	☐ Yes ☐ No ☐ Unsure

Disability/Medical Diagnosis
(please provide supporting documentation to assist us in processing this application)

What is the child's **primary/main** disability? **Please tick (✓) one box only:**

- ☐ Acquired Brain Injury
- ☐ Specific Learning – other than Intellectual
- ☐ Autism Spectrum Disorder
- ☐ Intellectual
- ☐ Down Syndrome
- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Cerebral Palsy
- ☐ Motor Neurone Disease
- ☐ Muscular Dystrophy
- ☐ Para / quadri (tetra) / hemiplegia
- ☐ Spina Bifida
- ☐ Psychiatric Disability
- ☐ Deaf blind – dual sensory
- ☐ Vision
- ☐ Hearing
- ☐ Speech Impairment
- ☐ Other (please specify) _____

Does the child have any **other** disability? – **you may tick (✓) more than one box:**

- ☐ Acquired Brain Injury
- ☐ Specific Learning – other than Intellectual
- ☐ Autism Spectrum Disorder
- ☐ Intellectual
- ☐ Down Syndrome
- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Cerebral Palsy
- ☐ Motor Neurone Disease
- ☐ Muscular Dystrophy
- ☐ Para / quadri (tetra) / hemiplegia
- ☐ Spina Bifida
- ☐ Psychiatric Disability
- ☐ Deaf blind – dual sensory
- ☐ Vision
- ☐ Hearing
- ☐ Speech Impairment
- ☐ Other (please specify) _____

Is the child receiving services from a disability services provider? *If yes please tick (√)* Therapy Focus ☐ OTHER ☐	If other Disability Service Provider please provide details: Organisation: _____ Contact Name: _____ Phone No: _____
Does the child have problems with: *Please tick (√) all that apply*	☐ Day Wetting ☐ Nocturnal Enuresis/ Bedwetting ☐ Constipation ☐ Faecal incontinence /soiling ☐ Toilet Training ☐ Other – (***please specify***)_____

Please describe the main concern (e.g., incontinence, soiling, need assistance with toilet training)	***Please describe:***
Do you require advice, assistance or information on the following? *Please tick (√) all that apply*	☐ Nappies and/or pads ☐ Continence products ☐ Toilet training ☐ Subsidies for nappies and/or pads ☐ Other:_____
Has there been any previous continence advice or management?	***Please describe:***
Is the child currently taking any medicines or supplements for bladder and bowel problems?	*Please list medicines taken* _____ These medications were prescribed by: Doctor/Specialist Name: _____ Medical Centre Name: _____ Address: _____ PH: _____ Fax: _____
How does the child communicate?	☐ Verbal ☐ Non Verbal - what other forms of communication are used? _____
Does the child have any mobility issues?	***If yes, please describe:***
Please provide details of the person completing this form, if different to the Parent/Carer/Guardian	First Name: _____ Surname: _____ Title/Designation:_____ Organisation: _____ Postal Address: _____ _____ Phone No: _____ Fax: _____ Email: _____
Please provide details of other agencies involved in the child's care	Organisation: _____ Contact Name: _____ Phone No: _____
Does the child attend any of the following? *Please tick (√) all that apply* ☐ Day Care ☐ Kindy ☐ School ☐ Home school	Name: _____ Address: _____ School Year: _____ Phone No: _____ Name of Centre: _____

☐ Respite ☐ After School Care ☐ Vacation Care	Address: _____ Phone No: _____ Days attending: _____
If your child has an Occupational Therapist please provide details:	Name of OT: _____ Organisation: _____ Email : _____ Phone No: _____
Please provide details of GP/Family Doctor or Specialist involved in your child's bladder and/or bowel management if not already provided	Name of Doctor: _____ Medical Centre Name: _____ Address or Department: _____ Phone No: _____ Fax No: _____

Checklist:
To ensure that this referral is processed promptly please check that this referral includes the following supporting documentation and that you have signed the consent details on page 6.

☐ Proof of Australian Permanent Residency (eg copy of birth certificate*, Passport, Visa. * If parents are born overseas please provide details of the Permanent Residency Visa)

☐ Proof of current address in Western Australia (e.g. phone bill, electricity bill)

☐ Letter from a doctor or registered health care professional confirming your child's disability diagnosis/ medical condition; **or**

☐ NDIA Plan stating that your child's plan includes a toileting program or continence management

☐ Consents have been signed

Please go to page 6 for Consent details and for information about where to send this form. If you have any queries regarding this form or need assistance to complete this form please contact our friendly administration staff on 9478 9500 or email enquiries@therapyfocus.org.au

To assist in prompt processing of this referral please provide consent to allow for sharing of information and providing services as below

Consent to Exchange Information (Please tick (✓) as appropriate):

☐ I/We give consent to Therapy Focus to contact my/our child's Family Doctor/General Practitioner and Medical Specialist/s to exchange information including reports.

☐ I/We consent to information regarding my/our child being shared between my referrer and PEBBLES.

☐ I/We give consent for PEBBLES to exchange information with **all the other agencies, service providers and health care professionals** listed on this form.

☐ I/We give consent for my/our child to receive services from PEBBLES.

☐ I/We understand that this consent remains valid while my/our child is receiving services from PEBBLES and I/We agree to notify PEBBLES of any changes which may affect this consent.

☐ I give consent for PEBBLES to use my/my child's personal information in de-identified form for research purposes, including the presentation of such information at public seminars and conferences and in relevant publications.

☐ I/We consent to being contacted by the Independent Evaluator, Ms Linda Orton, to provide feedback on the service.

Please tick if you would like to receive the following:

☐ Quarterly *In Focus* Newsletters
☐ Monthly *Family Focus* e-newsletters
☐ Emails about events and activities conducted by Therapy Focus and partner organisations

Printed Name: …….. Printed Name: ……

Signature: …….. Signature: ……..

Date: …… Date: ……

Please return this form using any of the options below:

1. **Email**: enquiries@therapyfocus.org.au
2. **Fax**: (08) 9451 5480
3. **Post**: PO Box 20 BENTLEY WA 6982

General enquiries: (08) 9478 9500 **Appointment enquiries**: 1300 865 401

Service Providers' Obligations under the *Privacy Act 1988*

All Disability Professional Service Providers are bound by the *Privacy Act 1988*. As such, **Therapy Focus** undertakes to adhere to the National Privacy Principles which appear in Schedule 3 of the Privacy Act; which regulate how we may collect, use, disclose and store personal information and how individuals may access and correct personal information held about them. For further information please refer to www.privacy.gov.au or www.comlaw.gov.au