Medical Referral Form

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.

PEBBLES deliver services to children with special needs, including those supported by NDIA and MyWay. Please ask the family to contact Therapy Focus on 9478 9500 to discuss the application process.

Referral 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 or MyWay Plan

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

This form should be submitted along with the Parent/Carer/Guardian Referral Form*

Please return this form using any of the options below:

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

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

***Copies of this form can be accessed from Therapy Focus:**

PH: 9478 9500 **Web: www.therapyfocus.org.au** **Email: enquiries@therapyfocus.org.au**

Referrer Details

Date: ……/……/……

Area of Practice: ☐ **General Practice** ☐ **Paediatric Gastroenterology** ☐ **Paediatric Urology** ☐ **Paediatrician** ☐ **Other** _____	First Name: _____ Surname:_____
Practice Name/Hospital	
Address/Department	
Contact details	Phone No: _____ Email: _____

Client Name	First Name: _____ Surname:_____
DOB	/ / **Gender:** ☐ Female ☐ Male
Parent/Carer/Guardian Name	First Name: _____ Surname:_____
Parent/Carer/Guardian Contact Details	Address: _____ _____ Post Code: _____
Contact Numbers & Email Address	Phone No: _____ Mob No: _____ Email: _____
Disability/Medical Diagnosis	
Presenting Continence Issue	
Current Medications for Bladder / Bowel Problems	
Other Medications	
Medical/Surgical History	
Medical Summary	