

## MUSIC THERAPY REFERRAL FORM - 2022

### Step 1: Client Details

Client Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Address: \_\_\_\_\_

Tel: \_\_\_\_\_ Mobile: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Significant medical history/Alerts : \_\_\_\_\_

Health professionals currently involved with the client: \_\_\_\_\_

### Step 2: Reason for Referral

<input type="checkbox"/> <b>Motor</b> <input type="checkbox"/> Gross motor <input type="checkbox"/> Fine motor <input type="checkbox"/> Gait <input type="checkbox"/> Finger isolation	<input type="checkbox"/> <b>Sensory</b> Brief description of sensory needs: _____ _____
<input type="checkbox"/> <b>Activities of Daily Living</b> <input type="checkbox"/> Transferring <input type="checkbox"/> Oral care <input type="checkbox"/> Walking <input type="checkbox"/> Climbing stairs <input type="checkbox"/> Eating <input type="checkbox"/> Housework <input type="checkbox"/> Other _____	<input type="checkbox"/> <b>Communication</b> <input type="checkbox"/> Expressive <input type="checkbox"/> Receptive
	<input type="checkbox"/> <b>Emotional</b>
	<input type="checkbox"/> <b>Cognitive</b>
	<input type="checkbox"/> <b>Social</b>

Brief description of reason for referral:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Referral completed by: \_\_\_\_\_ Date: \_\_\_\_\_

**Please return to:**

New England Conservatorium of Music  
 PO Box 1313 Armidale, 2350  
 CB Newling Building, Mossman & Faulkner Sts  
 Tel: 6788 2135

**Direct enquiries can be made to:**

Fumie Takahashi (Registered Music Therapist)  
 Email: [musictherapy@necom.org.au](mailto:musictherapy@necom.org.au)