Music Therapy Referral Form

Name: First names Surname	Please circle one M / F	Date of Birth:
Diagnosis:		
Ethnicity:		

Name of caregiver/s:	
Postal address:	Postcode:
Contact details: Home: Mobile:	 Work: Email:

Other professionals	Service History	Contact details
Speech Language Therapist Name:		Tel: Email: Report: Yes ☐
Physiotherapist Name:		Tel: Email: Report: Yes ☐
Occupational therapist Name:		Tel: Email: Report: Yes ☐
GP/Physician Name:		Tel: Email: Report: Yes
Other: Name & contact details: Medication? Yes ☐ No ☐ Details: Previous music therapy? Yes ☐ No ☐ Details:		

Reason for referral:

Hopes and expectations:

Conditions that the music therapist needs to be aware of: (epilepsy, challenging behaviour, etc..)
Means of communication: (Speech, Makaton, etc..) Languages used at home:
Any relevant strengths or difficulties:

Preferred Day & Time____

Preferred means of communication:

☐ Email ☐ Phone ☐ Post

Referred by: _________________________________ **Date:**________________

Relationship to client: _________________________ **Signed:**______________

*Where did you hear about RMTC?*____

*Please return this form to RMTC, **15 Surrey Crescent, Grey Lynn, Auckland 1021***
info@rmtc.org.nz