Raukatauri
Music Therapy Centre
www.rmtc.org.nz

Music Therapy Referral Form

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

Name of parents/caregivers:	
Postal address: Postcode:	
Contact details: Home: Mobile:	Work: Email:

Sibling's Names & DOB

Name of School:		
Address: Postcode:		
Name of contact:	Position:	Tel:
(for office use) Permission to contact? Yes ☐ No ☐	Latest IEP Received? Yes ☐	

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 ☐
Paediatrician 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_____

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***

CONSULTATION *(for office use)* ***Date***_____

Case History & Background

Exploratory Session Notes

CHECK LIST

- ☐ Session type
- ☐ Cost of therapy discussed
- ☐ Policies on confidentiality and safety
- ☐ Parent and carers guide given