Music Therapy
with Shari

CONFIDENTIAL

Referral Form

First Name(s):	**Date of Birth:** **Age:**
Surname:	**Ethnicity:**
Diagnosis/Condition(s):	
Family (Names and relationship/role):	

Contact details for key liaison(s) - Parents/Family/Caregivers/Organisation rep/Facility rep
Name:
Address:
Email:
Phone/Mobile number(s):

Referral for Music Therapy Service *Please indicate your preference:*

Type of sessions: ☐ Individual ☐ Pair ☐ Group

☐ One-off Consultation (session and meeting) ☐ Initial ___week assessment sessions ☐ Ongoing weekly sessions

Reason for referral, hopes and expectations for this person attending music therapy

About their music **(past experiences, instruments play/ed; favourite instruments, songs, musicians, music genres/eras etc)**

Strengths, interests, hobbies

Difficulties, concerns, and conditions Shari needs to be aware of (e.g. epilepsy, physical needs, behaviours)

Cultural, spiritual or any other needs

Other therapy services accessed, details: **What they enjoyed and want to continue with Shari:**

☐ Music Therapy _____
☐ Speech Language Therapy_____
☐ Occupational Therapy _____
☐ Physiotherapy _____
☐ Other:

Please email to: shari.storie@outlook.co.nz

Signed:_____

Relationship to client:_____ **Date:**_____