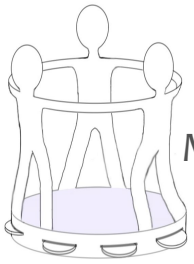

Music Therapy
with Shari

CONFIDENTIAL

Referral Form

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

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

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

Type of sessions: ☐ Individual ☐ Pair ☐ Group

☐ Consultation (session and meeting)

☐ Assessment period

☐6 or ☐10 sessions (weekly)

☐ Review meeting and report ☐Report only

If agreed to continue therapy following the assessment and review, please indicate your potential interest:

☐ Short-term block of up to _____ months

☐ Long-term ongoing with ___ - monthly reviews

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

Strengths and difficulties

Conditions Shari needs to be aware of (e.g. epilepsy, physical needs, behaviours)

Other therapy services accessed (please specify professionals' names and contact details if current):

☐ Music Therapy

☐ Speech Language Therapy

☐ Occupational Therapy

☐ Physiotherapy

☐ Other:

Where you heard about Music Therapy with Shari

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

Signed:_____

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