

This form is to be completed in advance of any NDIS service provision commencing in school.

***ONE*** *FORM MUST BE USED* ***FOR EACH*** *INDIVIDUAL THERAPIST REQUEST*

**WILLIAM DEAN PUBLIC SCHOOL**

**REQUEST FOR THERAPY SERVICE PROVISION IN SCHOOL**

|  |  |  |  |
| --- | --- | --- | --- |
| Student  Name: |  | Class  Teacher: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Therapy Requested:** | Speech Therapy | | Occupational Therapy |
| Physiotherapy | Behaviour Support | | Other: |
| **Organisation:** | | **Therapist name:** | |

|  |
| --- |
| **Funded by:**  NDIS  Parent  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |
| --- |
| What is your expected outcome to be achieved with this therapy?  **Please attach a copy of the students NDIS or private practice plan goals (page 2 of NDIS plan documentation)** |
|  |

|  |  |  |
| --- | --- | --- |
| **Frequency of Service**  **(e.g. weekly, Fortnightly, one off)** | **Session time**  **(e.g.30 minutes)** | **Duration of Service**  **(e.g.Term 2)** |
|  |  |  |

|  |  |  |
| --- | --- | --- |
| In some cases, the addition of visitors and guests in classrooms can disrupt or divert student focus during therapy session. In these cases, more focused therapy/ results can be achieved at external venues. Is the delivery of this service necessary during school hours? If yes, please state why: | Yes | No |

|  |  |  |  |
| --- | --- | --- | --- |
| **To be completed by the Therapist:** | | | |
| I consent to providing input into a review meeting with classroom staff? | | Yes | No |
| I consent to providing regular written feedback to the classroom teacher regarding student therapy progress? (minimum once per school term)? | | Yes | No |
| Therapist email address: |  | | |

***William Dean Public School reserves the right to deny or terminate this agreement if at any time it is determined that the school therapy unduly disrupts the education of our students.***

|  |  |
| --- | --- |
| **Therapists Signature:** | **Date:** |
|  |  |

|  |  |
| --- | --- |
| **To be completed by the Parent:** | |
| Parent name: |  |
| Parent email address: |  |
| I understand that a decision will be made regarding the provision of therapy services during school hours after extensive, collaborative consultation and negotiation with parents, carers, staff and the Student Wellbeing and Engagement Team as appropriate. | |

|  |  |
| --- | --- |
| **Parents Signature:** | **Date:** |
|  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **OFFICE USE ONLY** | | | | | |
| Approved |  | Declined |  | On hold/Review |  |

|  |  |
| --- | --- |
| **Principal / Deputy Principal Signature:** | **Date:** |
|  |  |

|  |  |
| --- | --- |
| **INFORMATION / DOCUMENTATION REQUIRED**  Attach all documentation as requested | |
|  | Therapist organisation – Name of the company they work for |
|  | Therapist full name |
|  | Therapist email address |
|  | Expected outcome – please note: an educational goal must be identified for therapy in school to proceed |
|  | A copy of the students plan goals (NDIS or Private) |
|  | Frequency of service request |
|  | Length of session required |
|  | Duration of the service |
|  | Therapists consent to providing input into a review meeting with LaST team |
|  | Parents email address |
|  | Signed and dated by Therapist and Parent |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **ACTIONS** | | | | | |
| Added to database & Sentral |  | Scanned to file |  | Emailed outcome to parent |  |