



STUDENT PROFILE

Name		School		School Year	
Age		DOB		Date	

Reason for referral		Current school(s) & dates	
		Previous schools & dates	

Parents/Carers		Contact Information	
Nationality & Cultural background, Other languages spoken at home		Aboriginal/Torres Strait Islander? <input type="checkbox"/> Yes	
Family Background			
Agencies currently involved with the family or child			

Previous Interventions		When	
DEC Disability Confirmation		Valid	
Diagnosed Mental Health Conditions		Diagnosed by who and when	
Health Concerns and Medication		Health Care Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Likes and interests		Dislikes	
Cognitive ability	<input type="checkbox"/> Never tested <input type="checkbox"/> Average range <input type="checkbox"/> Mild intellectual disability - IM <input type="checkbox"/> Moderate intellectual disability - IO		
Speech & language			
Fine motor concerns		Gross motor concerns	
Sensory processing disorder		Vision or hearing	
Relates best to		Difficulty relating to	
Behaviour concerns			
Academic strengths		Academic difficulties	