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Allied Health Services
School Support Request Form

When completed, please return to:	
Email: Complete with your region's information	**Fax:** Complete with your region's information

Date of Request:		
Student Information		
Student's Name:		DoB:
Request Initiated by:		
Name:		Position:
Ph:		Email:
School Information		
School:		
Class:	**Teacher:**	
Any other relevant staff in regard to the request (e.g. AVT, Therapists, HOSES):		
Name:	Role:	Contact:
Name:	Role:	Contact:
Name:	Role:	Contact:
☐ A copy of the student's current ICP or ISP is attached. (Please ensure that the student's ICP, ISP or identified educational adjustments are attached to this request form to assist with processing.)		
Support Requested Please indicate support requested (tick):		
☐ Occupational Therapist	☐ Physiotherapist	☐ Speech & Language Pathologist
Details of Request (this must be linked to the student's ICP, ISP or identified educational adjustments):		
If school visit requested, please indicate the best times (e.g., at lunch time for a mealtime review):		
Has the parent / caregiver been notified of this request?:	☐ Yes	☐ No
Request approved by: (Please note that all requests must be approved by the Principal or the Principal's nominee).		
Name:	Position:	
Signature:		
If you have any additional queries please contact CPL staff or make a note on this form and they will be able to discuss how to provide any additional/alternative services to meet your school's needs.		

OFFICE USE ONLY **- Allied Health Manager to complete**		
Date Received:	Date Receipt of Request Sent:	Date Actioned: