Perth Children's Hospital
15 Hospital Avenue
Nedlands Western Australia 6009
Locked Bag 2010 Nedlands WA 6909
Phone (08) 6456 0383 Fax (08) 6456 2016
ssenmmh.wa.edu.au

School of Special Educational Needs
Medical & Mental Health

CONSENT FOR INFORMATION EXCHANGE

The role of Department of Education, School of Special Educational Needs: Medical and Mental Health (SSEN: MMH) teachers attached to Department of Health teams, is to provide support for your child's educational and/or school transition needs. Your consent is sought to contact your child's school and/or associated Education Office or Student Services Team for relevant information.

This information will be used and shared with the health team and other appropriate agencies as necessary to assess, support and enhance your child's educational outcomes and will include sharing digital work records and samples, which may contain photos. The ongoing exchange of information will continue while your child is being supported by SSEN:MMH.

Health teams, in conjunction with SSEN:MMH, occasionally utilise information obtained from schools for the purposes of monitoring and evaluating the effectiveness of the programs we offer to your child and others. All data used will be de-identified. If you would like further information or have any concerns then please telephone 6456 0383. If you should choose to withdraw your consent then please advise me in writing.

Thank you for your support.

Yours sincerely

CALEB JONES
PRINCIPAL

Student Name:	**Date of Birth:**
Parent / Legal Guardian:	
Home Address:	
Parent / Legal Guardian Email Address:	
Telephone:	**Alternative Contact:**
Name of School:	**Year Level:**

I give my consent for the above school, associated Education /Student Services Office or other relevant Agency to be contacted. I understand any information exchanged will only be used for the stated purposes.

Signed Parent/Legal Guardian:	**Relationship to student:**
Witness Name:	**Date:**
Signature:	**Date:**

NB: For students under 18 years of age it is only the parent/legal guardian who can complete this form. If the referring medical practitioner feels that this is not appropriate because the student is deemed to be a mature minor, then the medical practitioner must provide signed and dated certification confirming thestudents mature minor status.

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REFERRAL TO SSEN:MMH TEACHER

Student Name:	Attach Client ID Label here

☐ Please tick if Aboriginal and/or Torres Strait Islander
☐ Please tick if English is not first language

Diagnosis: (if applicable/known)

Please tick purpose of referral or state in other:

☐ Gather school feedback
☐ Support the development of documented plans
☐ Make classroom observations
☐ Provide school staff with information to manage student's health condition
☐ Assist parent engagement
☐ Support Transition plans
☐ Hospital Teaching support
☐ Home Teaching support * End dated Medical Certificate is required

Other/Details:	

Please indicate below any other health professionals and/or agencies involved with this student.

Referrer	Name:	Role:
Health Team		
Email:		
Signed:		Date:

SSEN:MMH teacher will provide information to the Health team at agreed intervals and when referral is completed.
Follow up referrals for students are welcome by completing a new referral form.

NB: Referral cannot be processed until a SSEN:MMH consent form is signed, witnessed and returned with this referral.

Please email consent and referral to: ssenmmh@education.wa.edu.au