SEEDS OCCUPATIONAL THERAPY

Functional Capacity Assessment

Charlie John Citizen

SAMPLE REPORT · FICTITIOUS PARTICIPANT

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Confidential — prepared to support NDIS planning and review.

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CHAPTER 1

Participant Overview and Assessment Context

Charlie John Citizen is an eight-year-old boy, born in 2018. He lives in Melbourne's western suburbs, in a single-storey three-bedroom family home with his mother, Jane, his father, John, and his eleven-year-old brother, Lucas, who is in Year 5 at the same school and has no additional needs. His paternal grandmother lives about ten minutes away; she collects Lucas from school most days and can mind Charlie for short, supervised periods, but finds his meltdowns difficult to manage and is not an unsupervised backup. Jane works two days a week as a pharmacy retail assistant, having reduced from full-time work in 2024 because of Charlie's needs. John works full-time as a machine operator on rotating early shifts.

Charlie is an existing NDIS participant. His current 12-month plan is plan-managed by Jane and includes an Improved Daily Living (Capacity Building) allocation, which funds weekly occupational therapy, in place since March 2025, and fortnightly speech pathology, together with a small Core consumables allocation; all other categories are unfunded. This functional capacity assessment was completed by a Seeds Occupational Therapy occupational therapist in July 2026, to support Charlie's scheduled plan reassessment. Information sources included interviews with both parents, the intake questionnaires they completed, written and telephone collateral from his classroom teacher, the available paediatric, diagnostic psychology and speech pathology documentation, and standardised measures administered for this assessment.

Charlie was diagnosed with Autism Spectrum Disorder Level 2 (substantial support required) in September 2022, at age four, following multidisciplinary assessment by a developmental paediatrician and psychologist, without intellectual impairment. He has a co-occurring mixed receptive-expressive language disorder, identified when concerns were raised at age three, and has received speech pathology since early 2022. His developmental paediatrician raised a query of ADHD in late 2025, and a formal diagnostic review is scheduled for the second half of 2026; ADHD is treated throughout this report as suspected, not confirmed.

The family's concerns are practical and consistent across settings: mornings that take an hour of adult direction, a diet of about fourteen accepted foods, meltdowns several times a week at home, an inability to manage busy community environments, safety in carparks and near roads, and a household that functions only because both parents run it around their work. The reason for this assessment is to describe the functional impact of Charlie's impairments as he progresses through primary school, to assess whether the current therapy-only plan matches his needs, and to inform the supports sought at reassessment, which include continued capacity building and, for the first time, a modest allocation of Core support hours. The central task is to describe the gap between what Charlie can do with full adult support and what an eight-year-old is ordinarily beginning to do without it, and the load his family carries in maintaining that support.

CHAPTER 2

Disability, Diagnosis and Impairment Profile

Charlie's primary impairment is Autism Spectrum Disorder Level 2, diagnosed in September 2022 by a developmental paediatrician and psychologist following multidisciplinary assessment, without intellectual impairment. Cognitive assessment at diagnosis (WPPSI-IV) placed his overall ability in the average range, with relative weaknesses in working memory and processing speed. Autism is a lifelong neurodevelopmental condition. Its core features — sensory processing differences, social communication differences and restricted, repetitive patterns of behaviour — are permanent and do not resolve with treatment. Therapy builds skills and participation, but it does not remove the underlying impairment, and Charlie's needs should be expected to change in form rather than disappear as he grows.

His mixed receptive-expressive language disorder was identified after concerns were raised at age three, and he has received continuous speech pathology since early 2022. Functionally, he speaks in short sentences, relies heavily on delayed echolalia, interprets language literally, and manages single-step instructions with visual support; his comprehension and expression both reduce further under stress. His language difficulties affect the functional domain of communication and are considered within his broader neurological and cognitive profile. Four years of sustained intervention have produced real gains in structured settings, and the functional gap against same-age peers remains substantial.

His developmental paediatrician raised a query of ADHD in late 2025 on the basis of his attention, impulsivity and activity levels across settings, and a formal diagnostic review is scheduled for the second half of 2026. Rating scales completed for this assessment are consistent with that query and are reported in the standardised measures chapter, but no ADHD diagnosis has been made, and nothing in this report relies on one. If the review confirms the diagnosis, it will inform therapy targets and any medical management, which sits with the paediatrician.

Charlie also has eczema, managed by his general practitioner with a parent-applied emollient routine. Flares worsen his clothing tolerance and his sleep. It is noted for completeness and is not relied on in this report.

His developmental history is consistent with lifelong impairment. He was born at term, walked at around fourteen months, produced first words at around twenty months, and did not combine words into phrases until after three. His childcare educators raised concerns at three about his response to his name, his solitary play and his distress at transitions, which led to referral and diagnosis at four. He was day toilet-trained at four and a half and has not yet achieved overnight continence. On paediatric advice his school entry was deferred a year; he started Foundation in 2024 and is now in Year 2 at his local mainstream government primary school, the same school Lucas attends.

His impairments interact and amplify one another. Sensory overload consumes the capacity he needs for language processing; his language difficulties leave him without the words to seek help before overload tips into meltdown; and his executive difficulties mean that even well-practised routines collapse without an adult holding the sequence. His impairments fall within the neurological, cognitive and sensory categories, with his language impairment affecting the functional domain of communication. They are permanent or likely permanent, and they substantially reduce his functional capacity compared with children of his age.

CHAPTER 3

Functional Capacity Summary

Charlie's physical development is age-appropriate. He runs, climbs and jumps confidently, has had no falls of concern, and needs no mobility equipment. He has genuine strengths: a strong visual memory, sustained attention for interest-led tasks — he completes 200-piece jigsaw puzzles independently and builds elaborate toy train track layouts of his own design — detailed knowledge of the Melbourne train network, warm attachment to his parents, and academic skills at or near year level in structured literacy and numeracy tasks when supported. These strengths are clinically meaningful entry points for therapy. They do not offset his dependence.

Across daily life, Charlie functions well below age expectations and only inside adult-built structure. Every routine — waking, dressing, meals, bathing, bedtime — runs on step-by-step adult prompting, and most involve some hands-on help. His eating is restricted to about fourteen foods under specific conditions. His communication does not yet extend to asking for help or reporting what has happened to him, which affects his safety and his health care. He has no reciprocal friendships and cannot yet manage unstructured time with peers. His community access is confined to short, familiar, quiet outings with close supervision, and he requires arm's-reach supervision in carparks and near roads at an age when peers are beginning to walk short distances independently.

His functioning is variable, and judging him by a good day would overestimate his capacity. On a good day — after a settled night, inside a predictable routine — he dresses with verbal prompts only, eats his usual foods at the table, manages the school day with his teacher's adjustments, and plays contentedly with his puzzles and trains. On a hard day — after a poor night, an eczema flare, or a demanding previous day — the morning routine stalls at each step, he may refuse school, his food range narrows further, and small triggers produce the meltdowns described in the sensory chapter.

What looks like managed function is a parent-delivered support system operating continuously. Jane has halved her working hours to run it; John covers the components his shift roster allows; his grandmother's help is limited to short supervised stretches; and Lucas, at eleven, is increasingly drawn into watching his brother. The arrangement currently meets Charlie's needs. This report describes what it costs to maintain, how sustainable it is, and which supports would build Charlie's own capacity while reducing the load on the people providing it.

CHAPTER 4

Self-Care and Daily Routines

Charlie's self-care skills are emerging but none is yet independent, and all of them run on adult scaffolding well beyond what an eight-year-old ordinarily needs. His mornings take forty-five to sixty minutes of step-by-step direction. His clothes are laid out the night before, and he tolerates only a narrow set: softened trackpants, loose polo shirts, socks turned inside-out so the seam sits away from his toes, and velcro shoes. With an adult prompting each step he dresses himself apart from occasional hands-on help with orientation and fastenings; without prompting, he stalls between steps and drifts to his trains. A disrupted morning — a missing shirt, a changed plan, a poor night — cascades, and those are the mornings school refusal appears.

His hygiene follows the same pattern. Tooth brushing needs hand-over-hand finishing to be effective. Bathing is prompted throughout, and hair-washing happens once or twice a week with distress, managed by his father on set nights. Haircuts have always been done at home — his father cuts his hair during screen time — because he has never tolerated a barber. He was day toilet-trained at four and a half and is reliable by day with prompted toileting at transitions, but overnight continence has not yet been achieved and he wears a pull-up to bed at eight, a gap his parents manage matter-of-factly and he is beginning to notice.

Eating is the most restricted area of his self-care. Charlie accepts about fourteen foods — plain pasta, plain rice, one specific brand of chicken nuggets, white toast, banana, peeled apple cut into slices, vanilla yoghurt pouches, plain crackers, hot chips and milk among them — prepared and presented in consistent ways. Foods must not touch on the plate, and mixed dishes are refused. New foods produce distress rather than curiosity, and his parents do not force the issue. He eats separately from the family at about half of dinners, either earlier or at the bench, because the demands of a shared table exceed him on those nights. His parents use the iPad at the table because it keeps him seated and eating; mealtimes are not yet a reliable self-care task for Charlie and still need external regulation, and the screen is the strategy that currently makes

them work. His weight sits on the lower centiles but is stable, and his growth is monitored by his general practitioner, as described in the health chapter.

Sleep is a nightly task rather than a background function. Settling takes sixty to ninety minutes with a parent lying with him, he has taken melatonin since mid-2024 with partial benefit, and he wakes one to two nights a week — more during eczema flares, when night scratching disturbs him, and after high-demand days. His next-day capacity tracks his sleep closely, and the poor-night-to-hard-morning link is one of the most consistent patterns in his week.

Compared with same-age peers, who are ordinarily dressing, washing, toileting and eating with reminders rather than direction, Charlie's self-care depends on an adult delivering each routine, every day. The skills are emerging underneath the scaffolding, which is precisely why structured capacity building matters now; the supports that address this are set out in the recommendations.

CHAPTER 5

Health Management and Daily Reliability

Charlie remains dependent on adults for health management, with a level of monitoring that exceeds ordinary age expectations because he does not reliably notice or report what is happening in his own body. His interoception is markedly reduced. In 2025 he walked on a badly bruised foot for two days before his parents noticed a limp; he had not mentioned pain and could not say when it started. Hunger, thirst, fatigue and toilet urgency register late and bluntly, which is why his toileting is prompted at transitions, why his fluid intake is prompted through the day, and why illness in Charlie typically announces itself through behaviour — irritability, withdrawal, a rise in meltdowns — before any symptom is named. His parents have learned to read these signals; anyone supporting him must be taught to.

His medications and routines are entirely parent-managed. Melatonin 2 mg at night has been prescribed by his developmental paediatrician since mid-2024, with partial benefit as described in the self-care chapter. His eczema is managed by his general practitioner with an emollient routine his parents apply, stepped up during flares. Neither task can be handed to Charlie or left to chance.

Appointments are achievable with substantial preparation and are built around his profile: the first appointment of the day, the same general practitioner each time, and a photo-supported explanation beforehand. A recent dental check-up required two short visits because he could not tolerate the full examination in one sitting; the familiar family dentist accommodated this. His hearing was assessed as normal at age three and recent optometry review was normal. His developmental paediatrician reviews him six-monthly and will conduct the ADHD diagnostic review scheduled for the second half of 2026.

The consequence of his profile is that Charlie's health care runs entirely on adult vigilance — noticing, interpreting, preparing, accompanying and following through — with no contribution yet from Charlie's own reporting. The mainstream boundary is clear and is not in question: his

paediatrician holds diagnosis, medication and the ADHD review; his general practitioner holds his eczema, growth monitoring and general health; and nothing recommended in this report replaces them. The disability-related need sits alongside them: building Charlie's interoceptive awareness and his capacity to communicate pain, illness and need — the skills that would let him participate in his own health care — which is addressed in the recommendations.

CHAPTER 6

Domestic Life and Home Environment

The family home presents no physical barriers. It is a single-storey three-bedroom house with no steps and no environmental hazards identified; the side gate has been fitted with a self-closing lock, a control described with the incident that prompted it in the mobility chapter. The domestic picture is functional: a household extensively adapted around Charlie, and a child whose participation in home life sits well below age expectations.

At eight, children are ordinarily beginning to hold small responsibilities — setting the table, packing their school bag, tidying their room with reminders. Charlie manages none of these independently. He packs his school bag only with a laminated visual checklist and an adult checking the result. Tidying his room means an adult alongside him naming each step, and a task started alone is abandoned within minutes when the sequence drops out from under him. His "jobs" succeed as shared activities and fail as delegated ones, and the gap between him and Lucas at the same age is one his parents feel keenly.

The household itself is organised around his needs in ways the family now barely notices. Dinners follow a predictable weekly pattern anchored to his accepted foods. Tolerated clothing is bought in multiples when a line is discontinued. Vacuuming happens while he is at school. The television volume is capped. Furniture stays where it is, because rearranged rooms distress him. Each adaptation is small; together they show how extensively the household is organised around his needs.

The supervision load is the heaviest domestic demand. Charlie cannot be left unsupervised in the way an eight-year-old ordinarily can — not because he seeks danger, but because overload can produce bolting, as the mobility chapter describes, and because his late interoception means he does not flag his own needs. He has short periods alone in his room with the door open; beyond that, an adult is on duty whenever he is awake. This shapes everything else in the house: errands are run by one parent while the other stays home, jobs around the house happen

in fragments, and the two-adult arrangement described in the community chapter governs any outing involving both boys.

Charlie's domestic support needs are disability-related and require a level of adult input materially greater than expected at his age. The burden is currently absorbed by his parents in full, at the cost described in the informal supports chapter, and the supports that would build his participation and relieve the load are set out in the recommendations.

CHAPTER 7

Mobility, Transport and Physical Safety

Charlie's physical mobility is intact and age-appropriate. He walks, runs, climbs and jumps without difficulty, has had no falls of concern, and needs no equipment. The concern is not physical capacity, but safety and reliability: his ability to move through ordinary environments depends entirely on adult supervision, because his safety awareness collapses under load.

The clearest example occurred in mid-2025, when Charlie was seven. Leaving a shopping centre after a difficult visit, already overloaded, he bolted across a carpark laneway toward the family car; his mother caught him between parked cars, and there was no injury. He was not being defiant — he was heading for the one safe, known object in an overwhelming environment — but the risk was real. Since then his parents apply a hand-holding or trolley rule in all carparks, the side gate at home has a self-closing lock, and supervision near roads is kept at arm's reach. Charlie can recite road rules accurately; he does not reliably apply them when dysregulated, and he does not dependably stop at kerbs on a hard day. The gap between what he knows and what he does under load is the central safety finding.

His school-based exits, described in the learning chapter, have so far stayed within school grounds, which is consistent with the pattern: he moves toward known safe places rather than simply away, and the risk concentrates in open, unfamiliar, traffic-adjacent environments.

Transport is by family car and works on familiar routes. He is driven the five minutes to school; the walking route involves a main-road crossing his parents do not yet trust him to manage even accompanied on a difficult morning. Longer or unfamiliar drives produce distress that climbs with duration. Public transport is used rarely and only off-peak with an adult — notable given his love of trains; the outing that does work is described in the community chapter.

There is no falls risk, no physical impairment and no equipment need. What Charlie requires is a level of supervision — arm's reach in carparks and near roads at eight — that same-age peers

are growing out of, together with structured teaching that converts his verbal knowledge of safety into applied skill. The supports that address this are set out in the recommendations.

CHAPTER 8

Communication, Cognition and Self-Management

Charlie's communication is the domain where the gap between surface and function is widest. He can talk — in short sentences, and at length and with genuine fluency about the Melbourne train network, its lines, stations and rolling stock. A stranger hearing one of his train monologues would overestimate his language significantly. His functional communication tells a different story. He relies heavily on delayed echolalia, borrowing scripts from favourite videos to fill conversational turns. He interprets language literally. He follows single-step instructions with visual support; two-step instructions fail without visuals. Asked an open question — "What happened at school?" — he answers with "good" or a script, and the question goes genuinely unanswered, which matters for his safety and his health care as much as his relationships.

The most consequential gap is that Charlie does not yet ask for help. When a task defeats him, a demand overwhelms him or something hurts, he acts — grabs, leaves, or melts down — rather than requests. His words reduce further under load, exactly when he needs them most. Building a reliable help-and-break request is a priority target in his current therapy; the same gap runs through the school exits, the meltdowns and the unreported foot injury described elsewhere in this report.

Cognitively, Charlie's assessment at diagnosis placed his overall ability in the average range with relative weaknesses in working memory and processing speed, and his day-to-day profile matches it. His visual memory is strong. His attention is sustained and deep when interest leads — the 200-piece jigsaws, the train track layouts built from his own designs — and fragile when it does not. He loses steps mid-task, cannot yet estimate time in any useful way, and needs an adult to initiate almost everything that is not self-chosen. Transitions are his most reliable point of failure, above all the transition away from a screen.

His self-management, referenced against age expectations, is nascent. Eight-year-olds are beginning to manage belongings, carry simple plans across a day and tell an adult when something is wrong. Charlie manages his belongings through the visual checklist and adult checking described in the domestic chapter, carries no plan without an adult holding it, and did not report the foot injury described in the health chapter. His strengths are real and they are the right entry points — visual-first teaching, interest-anchored practice — but they should not be mistaken for functional capacity. The main risk in how others read Charlie is that his fluency about trains is taken as his overall language level, and this distinction needs to be made clear to every adult who supports him. The supports that address this domain are set out in the recommendations.

CHAPTER 9

Sensory Processing, Regulation and Behaviour

Charlie's sensory differences are primary functional barriers, and sound is the dominant channel. Hand dryers make public toilets a flashpoint he covers his ears against or avoids; the school bell, assemblies and the vacuum cleaner are reliable stressors; and layered noise in busy environments accumulates quickly toward the overload described in the community chapter. His tactile sensitivities — seams, tags, hair-washing, wet or messy textures — shape his wardrobe, his hygiene routine and his participation in messy play at school, which he manages from the edge of. His oral sensitivities are expressed through the restricted eating described in the self-care chapter. Predictability moderates all of it: the same noise tolerated when expected is intolerable when sudden.

He is a sensory seeker as well as an avoider. He jumps on the backyard trampoline daily and it visibly settles him; he chews his sleeves and collars, and shirts are regularly ruined — a chewable pendant has been partially adopted, worn some days and refused others; he lines up his toy trains in long, precise arrangements; and he flaps his hands when excited or stressed. These behaviours are regulating rather than harmful; they are best understood and channelled rather than suppressed, and they form part of how he manages his own arousal.

His interoception, described in the health chapter, has a regulatory consequence: he does not feel himself approaching his limit, so he can reach overload with little warning for himself or the adults around him. This is why his meltdowns can appear to come from nowhere and why prevention has to be built into his environment and routines rather than left to his self-report.

Meltdowns occur three to four times a week at home and last thirty to forty-five minutes including recovery. The triggers are consistent: changed plans, the transition away from screens, and Lucas interrupting his lined-up trains or his routines. The shape is consistent too — crying, screaming, throwing whatever is at hand (a thrown remote cracked a tablet screen in 2025), door-slamming, and occasionally pushing Lucas if he approaches mid-meltdown. There is

no self-injury, and no aggression outside the meltdown context. Afterwards he is subdued and clingy and needs quiet. The only reliable de-escalation is parental co-regulation: a dim room, minimal words, a low voice and his weighted blanket — a routine both parents use and his mother delivers most reliably. The blanket is an informally acquired item that has never been formally assessed, which the recommendations address.

His current tools are partial. Over-ear defenders are used at assemblies and on noisy outings and he accepts them most of the time; the trampoline and his trains downregulate him at home; the pendant is intermittent. Most of his regulation is still done for him, by adults who read his signals and manage his environment. His meltdowns are overload responses, not defiance, and nothing in his presentation suggests behaviour requiring restrictive oversight — the appropriate response is the regulation-and-communication capacity building set out in the recommendations.

CHAPTER 10

Social Participation and Relationships

Charlie's family relationships are warm and secure. He is affectionate with both parents on his own terms — he seeks them out, shares his train discoveries with them, and when his mother is unwell he brings her his weighted blanket, which reflects a genuine empathy that his limited formal social skills can mask. His relationship with Lucas is genuinely mixed: there are good stretches of parallel play, jigsaws and trampoline games, and there is the friction of a brother whose interruptions are Charlie's most frequent meltdown trigger and who, at eleven, is increasingly cast as a minder. Lucas rarely brings friends home now. The sibling picture is developed further in the informal supports chapter.

Beyond the family, Charlie has no reciprocal friendships. His play alongside peers is parallel at best, and unstructured time with other children is where his school day most reliably fails, as the learning chapter describes. The closest thing he has to a friendship is a classmate who shares his interest in trains; on good days the two draw train lines side by side at lunch, an arrangement that works because it requires no negotiation. Birthday party invitations still arrive occasionally. He lasts about thirty minutes with a parent shadowing him, or the invitation is declined, and the family now declines most.

The event that best captures his social profile was a family wedding in November 2025. With heavy preparation — photos of the venue beforehand, a seat near the exit — Charlie managed the ceremony, which was structured, predictable and quiet. The reception defeated him within half an hour, and he spent most of it in the car with his father. The pattern generalises: he can participate in the formal, scripted portion of social life when it is prepared for, and unstructured social density exceeds him regardless of preparation, at the cost of one parent's presence for the duration.

His emotional understanding is emerging. He names feelings rarely and identifies them in himself only with prompting; his distress is expressed through behaviour, and his empathy

shows in actions rather than words. He has genuine social interest — he watches other children, and he is pleased when the train-drawing classmate seeks him out — which matters clinically, because motivation is present and skill is the gap.

The trajectory is the concern. At eight, peers' social worlds are accelerating into sleepovers, team sport and independent play, while Charlie's remains adult-mediated and is not widening on its own. Without structured support the foreseeable path is a widening gap and the isolation that follows it; the supports that address this are set out in the recommendations. No safeguarding concerns were identified. Charlie is a warmly parented child in a protective household, with the supervision needs described throughout this report.

CHAPTER 11

Learning, Participation and Meaningful Daily Roles

Charlie is in Year 2 at his local mainstream government primary school, following a paediatrician-advised deferred entry, with no funded aide. His teacher provides a visual timetable, a front-row seat and an exit pass, and her collateral for this assessment — a completed questionnaire and a telephone discussion — was thoughtful and closely consistent with the parent report, which matters: his difficulties are the same difficulties across settings.

Within structured tasks and with those adjustments, Charlie works at or near year level. His decoding is solid and ahead of his comprehension, which his language disorder drags below it; his procedural number work is sound while worded problems defeat him for language rather than mathematical reasons. He can produce genuinely good work in a quiet room with a clear visual sequence; the structured curriculum itself is not the main area of difficulty.

His difficulties concentrate at transitions and in the less structured parts of the school day. Group work — turn-taking, negotiation, the verbal load of three other children — produces withdrawal or distress. Unstructured time is harder still: most lunchtimes he walks the fence line alone or shadows the yard-duty teacher, with the train-drawing arrangement described in the social chapter his best outcome on a good day. He exits the classroom two to three times a week when overloaded, usually to the corridor or sick bay. On one occasion earlier this year he left the building and was found in the school library, calm among the shelves; he had stayed on school grounds, and staff have since formalised the library as his named safe space, a constructive response within the school's remit. Assemblies are managed from the back row with an exit option, and he sometimes leaves partway with a staff member. His teacher also observes that mornings generally go better than afternoons, when accumulated demand shows in lower tolerance for group tasks and more frequent exits.

His attendance is the emerging concern. He missed eleven days in the first semester of 2026, most following poor nights or difficult previous days, and occasional morning refusal is now

part of the pattern described in the self-care chapter. The trajectory risk this represents is taken up in the risk chapter.

Outside school, the meaningful roles an eight-year-old ordinarily begins to hold — small jobs, small responsibilities — are largely unavailable to Charlie yet, for the reasons set out in the domestic chapter. The role he does hold, unprompted and with evident pride, is the family's train authority, and it is a real identity strength worth protecting and building on.

The boundary should be stated plainly. Curriculum adjustment, classroom supervision and any aide support are the responsibility of the education system, and this report does not seek them from the NDIS. School evidence is used here as functional evidence: the same impairments documented at home — sensory overload, communication breakdown, transition failure — produce the exits, the playground isolation and the attendance pattern. What appropriately falls to the NDIS is building the underlying capacities Charlie brings to school — regulation, functional communication, help-seeking — and those supports are set out in the recommendations.

CHAPTER 12

Community Access and Participation

Charlie's community access runs on four conditions: short, familiar, quiet, and closely supervised with one parent per child. Inside those conditions he participates genuinely. A weekly visit to the local library in its quiet weekday hours works, and he borrows train books. The park works early on Saturday mornings before it fills. His best outing is a Sunday-morning visit to a quiet railway station with his father to watch trains — interest-anchored, predictable, low-demand, and the closest thing he has to a community activity he actively looks forward to.

Outside those conditions, access fails, and the clearest example occurred in early 2026 in a shopping-centre food court at lunchtime. The noise and crowd stacked quickly; Charlie dropped to the floor with his hands over his ears, and it took his mother, crouched alongside him among onlookers, around twenty minutes to move him. The family has not attempted a busy-period shopping centre visit since. Groceries are done online, or one parent goes alone while the other stays home with the boys. The family no longer eats at restaurants — takeaway from a familiar local shop has replaced it. A single sensory-friendly cinema session was attempted and lasted about half the film. Swimming lessons, which most eight-year-olds in his community attend, were ceased in 2025 after repeated distress at the pool environment — the echoing noise and water on his face — which is both a participation loss and, at eight, an unfinished water-safety skill.

The supervision requirements compound the restriction. Any outing with both boys requires two adults, so single-parent outings happen with one child each, and the family almost never goes anywhere as a four. A demanding outing consumes the rest of Charlie's day in recovery, which caps frequency even for the outings that work.

The result is community participation well below age expectations, maintained by strategies — avoidance, off-peak timing, splitting the family — that preserve his day-to-day functioning while progressively narrowing the range of environments he experiences. Without graded,

supported practice, the accessible range does not widen on its own, and the family's current approach, entirely reasonably, prioritises avoiding distress over extending tolerance. Building that tolerance safely, including the carpark and road skills described in the mobility chapter and an eventual supported return to swimming, requires structured real-world work, and the supports for it are set out in the recommendations.

CHAPTER 13

Standardised Measures and Functional Interpretation

Standardised measures were administered to give structured, cross-setting support to the functional picture described throughout this report. They were selected to cover adaptive behaviour, behavioural screening from both home and school, the current ADHD query, sleep, parent-prioritised goals and carer load, and they are interpreted alongside the real-world examples rather than in isolation.

The Vineland-3 (Comprehensive Parent Interview, completed with Jane) produced an Adaptive Behavior Composite of 67, more than two standard deviations below the mean for his age. Daily Living Skills was his lowest domain at 63, consistent with the prompt-dependent self-care, restricted eating and absent household participation described in earlier chapters. Socialisation was 65, consistent with the absence of reciprocal friendships and the adult-mediated social world described in the social chapter. Communication was his relative strength at 74 — still well below average, and the profile matches the clinical picture precisely: language that is visible on the surface and substantially reduced in functional use. The gap between his average-range cognitive assessment at diagnosis and an adaptive composite of 67 is itself a central finding: his difficulty lies in the reliable application of his abilities in daily life rather than in the abilities themselves.

The Strengths and Difficulties Questionnaire was completed by both his mother and his classroom teacher. The parent total difficulties score was 24 — in the very high range — with hyperactivity 9 and peer problems 7 the most elevated subscales, emotional symptoms 5, conduct problems 3, and a low prosocial score of 4. The teacher total was 21, also very high, with the same two subscales — hyperactivity 8 and peer problems 7 — leading. The cross-informant agreement is clinically important: the elevated areas are identical at home and school, and the low conduct scores in both settings are consistent with a child whose difficulties are overload-driven rather than oppositional.

The ADHD Rating Scale-5 was elevated across both settings, with parent ratings at or above the 93rd percentile and teacher ratings at or above the 90th percentile across the inattention and hyperactivity-impulsivity domains. These results are consistent with the developmental paediatrician's query and have been forwarded to inform the diagnostic review scheduled for the second half of 2026. The diagnostic conclusion is deferred to that review, and this report does not treat ADHD as confirmed.

The Sleep Disturbance Scale for Children produced a total T-score of 71, in the clinical range, with the disorders of initiating and maintaining sleep subscale the most elevated — a direct match for the sixty-to-ninety-minute settling, the parental presence it requires and the night waking described in the self-care chapter.

The COPM was completed with both parents against their priority goals, each rated for importance, current performance and satisfaction out of ten. Managing the morning routine with fewer prompts was rated importance 9, performance 3, satisfaction 2. Broadening his food range and sharing family meals was importance 9, performance 2, satisfaction 2. Safe community outings, including carparks, was importance 10, performance 3, satisfaction 2. Communicating his needs before reaching meltdown was importance 8, performance 3, satisfaction 3. Independence in bathing and tooth-brushing was importance 7, performance 4, satisfaction 3. Mean performance was 3.0 and mean satisfaction 2.4 — very low across the goals the family rates most important. A change of two or more points on re-administration is clinically significant, and the COPM will serve as the primary review measure for this plan.

The Zarit Burden Interview short form (ZBI-12), completed by Jane, totalled 24, in the moderate range, with endorsement concentrated on the strain of balancing Charlie's needs against her work and Lucas's needs and on having insufficient time for herself. The texture is of sustained load rather than breakdown, which matches the informal supports chapter.

Across the measures the pattern is consistent and cross-setting: adaptive functioning more than two standard deviations below age expectations against average-range cognition, identical behavioural elevations reported independently by home and school, clinically significant sleep

disturbance, very low parent-rated performance on the goals that matter most to the family, and measurable carer strain. The measures corroborate the interview and collateral evidence and provide a defensible baseline for review.

CHAPTER 14

Informal Supports and Sustainability

Jane is Charlie's primary support, and the role reaches into every hour of his day. She runs the morning and evening routines, delivers most of the prompting his self-care depends on, manages the school relationship, books and attends every appointment, transports him to therapy, and is the most reliable deliverer of the co-regulation routine his meltdowns require. She reduced her work from full-time to two days a week in 2024 because the load was not compatible with more, an ongoing income and career cost the family absorbed without external support. Her sleep is interrupted by the settling routine and the night waking. Her measured strain, reported in the standardised measures chapter, is moderate, and its content — the balance against work and against Lucas's needs, the absence of time for herself — indicates sustained pressure that has not yet reached crisis point.

John's contribution is substantial and shaped by his roster. On rotating early shifts he leaves before the morning routine some weeks, and those weeks Jane runs the mornings alone. He owns the hair-washing nights and the home haircuts, shares the bedtime lying-with, and delivers the weekend outings, including the station mornings that are Charlie's best community access. The parents function as a coordinated two-person system whose capacity varies week to week with a shift roster neither controls.

The wider support network is limited. Charlie's grandmother collects Lucas from school and can mind Charlie for short, supervised stretches, but she finds his meltdowns difficult to manage, and she is not an overnight or unsupervised option. There is no other practical support. The family has never used respite in any form, and the parents have not been out together without the children in over a year.

The impact on Lucas is less visible but real. At eleven he is increasingly asked to watch Charlie for short stretches, his activities are scheduled around his brother's supervision needs, his interruptions are the most frequent trigger for the meltdowns described in the sensory chapter,

and he rarely brings friends home now. His parents see this clearly and are uncomfortable with it, which is to their credit; it is nonetheless what tends to happen whenever adult capacity runs short.

The arrangement works, and its sustainability is the concern. It depends on two adults running a continuous support system around full-time and part-time work, with a single point of failure: if Jane were unwell or unavailable, John's roster and the grandmother's limits mean the routine would not hold. It has already consumed half of Jane's working life, the couple's time together and a growing share of Lucas's ordinary childhood latitude. The purpose of the funded support recommended in this report is protective on both sides — to build Charlie's own capacity so the level of adult support can gradually reduce, and to add trained support that does not depend on one person's availability, so that the load on his parents reduces to a sustainable level and Lucas is not drawn further into a carer role.

CHAPTER 15

Key Risks and Safeguarding Considerations

The risks in Charlie's presentation are risks of unsafe access under overload, of participation and skill gaps widening with age, and of the informal support system wearing down — foreseeable, currently managed by informal controls, and preventable with structured support. The supports that address them are set out in the recommendations; this chapter states the risks, the current controls and the consequences of leaving them unaddressed.

Road and carpark safety is the most acute risk. The carpark incident described in the mobility chapter established the pattern: under overload, Charlie bolts toward safety without registering traffic, and his verbal knowledge of road rules does not survive dysregulation. The current controls — the hand-holding and trolley rule, the gate lock, arm's-reach supervision — are effective and entirely supervision-based; they contain the risk without reducing it, and they depend on an adult's hand being free at the wrong moment. The residual risk sits in transitions and open carparks on hard days, and the appropriate response is to keep the controls while building applied safety skill, which the recommendations address.

Nutrition is a chronic, compounding risk. Fourteen accepted foods, the no-touch rule, refusal of mixed dishes and separate meals half the week describe a food range with no margin: illness, a discontinued product or a further narrowing removes foods faster than new ones are added, and nothing is currently adding new ones. His weight is on the lower centiles but stable, and his growth is appropriately monitored by his general practitioner; the disability-related work of broadening tolerance is not something the health system provides, and at present it is not happening at all.

Sleep difficulties compound the other risks. The clinically significant disturbance measured in the standardised measures chapter drives the poor-night-to-hard-morning link, the school refusals that follow difficult nights, and a share of the meltdown pattern, while also

fragmenting his parents' sleep. Melatonin, appropriately managed by his paediatrician, is partial; the behavioural and environmental side of his sleep has had no structured attention.

School participation is a trajectory risk with early markers already visible: exits two to three times a week, playground isolation, and eleven days missed in a semester, most following poor nights. The school is responding well within its remit, and the pattern that produces the absences — sleep, morning-routine fragility, regulation — sits on the disability side of the boundary. Left alone, occasional refusal is how entrenched school avoidance starts, and it is far harder to unwind than to prevent.

Meltdown-related risk is real and bounded. Property damage has occurred once of note, and Lucas is occasionally pushed mid-meltdown; there is no self-injury and no aggression outside the meltdown context. This warrants monitoring and the regulation-and-communication work described in the recommendations. It does not, at present, approach the threshold for formal behaviour support, a position set out with its review trigger in the recommendations.

Water safety is a developing gap rather than an active risk: swimming lessons ceased in 2025, so at eight Charlie is closely supervised around water but is not acquiring water competence, an age-milestone gap the recommendations address through graded reintroduction when he is ready.

The structural risk beneath all of these is the sustainability of the informal system described in the previous chapter — a single point of failure in Jane, a roster-limited second adult, a grandmother at her limit, an eleven-year-old absorbing overflow, and no respite of any kind. If Jane's capacity lapses, every other risk in this chapter escalates together.

No safeguarding concerns were identified. Charlie is a loved, well-parented child in a protective and insightful household. The overall risk profile is one of gradual accumulation: a widening gap against same-age peers and increasing wear on the informal support system, unlikely to present as a crisis until late in its course, and preventable at this stage with well-targeted support.

CHAPTER 16

NDIS Disability Requirements and Section 24 Clinical Opinion

In my clinical opinion, the available evidence indicates that Charlie's impairments remain permanent, that they continue to substantially reduce his functional capacity across the domains relevant to section 24 of the NDIS Act, and that his disability requirements continue to be met at this reassessment.

The permanence basis rests on his Autism Spectrum Disorder Level 2, diagnosed in September 2022 following multidisciplinary assessment. Autism is a lifelong neurodevelopmental condition; therapy changes what Charlie can do with his impairment, and does not remove it. His mixed receptive-expressive language disorder has persisted through more than four years of continuous speech pathology — the gains are real and the functional gap against peers remains substantial, which is the pattern of a permanent or likely permanent impairment responding to support, not a resolving one. The suspected ADHD is under formal review and nothing in this opinion relies on it; his eczema is likewise noted and not relied on. The permanence requirement is met on the autism alone and reinforced by the persistence of the language impairment.

The substantial reduction in functional capacity, referenced against typically developing eight-year-olds, is documented across this report and corroborated across informants and settings. His communication is substantially reduced in functional use despite visible verbal output: he cannot reliably answer open questions, report pain or illness, or ask for help, and his adaptive communication measured at 74 sits well below age expectations. His social interaction is markedly reduced — no reciprocal friendships, parallel play at best, participation that fails in unstructured settings regardless of motivation. His learning is intact in structured tasks and substantially reduced at the point of application: group work, unstructured time and the generalisation of skills all require adult scaffolding his peers do not need. His mobility is physically intact while his safe mobility is substantially reduced — arm's-reach supervision in

carparks and near roads at an age when peers walk short distances independently. His self-care runs entirely on adult prompting and partial physical assistance, with restricted eating and incomplete overnight continence, and his adaptive daily living skills measured at 63. His self-management, referenced against age expectations, is the most reduced of all: he holds no routine, plan or responsibility without an adult holding it with him.

The reduction is present across home, school and community, corroborated independently by his parents, his classroom teacher, the treating team documentation and the standardised measures — including an Adaptive Behavior Composite of 67 against average-range cognition, and identical behavioural elevations from home and school — and it has persisted across four years of well-implemented early intervention and a household extensively engineered around his needs. Sustained, competent support has narrowed the gap in some areas but has not closed it in any domain, which is further evidence of the severity of the underlying impairments.

His support needs remain substantial and ongoing: daily adult support across self-care and routines, close supervision for community safety, structured capacity building in communication, regulation, eating and community access, and protection of an informal support system carrying demands not explained by ordinary childhood dependence. On the evidence, Charlie's impairments are permanent, they substantially reduce his functional capacity compared with children of his age across communication, social interaction, learning, mobility, self-care and self-management, and the reduction is evident across settings and over time. In my clinical opinion, the evidence supports the view that his disability requirements continue to be met.

CHAPTER 17

Recommendations and Section 34 Reasoning

Charlie's support needs sit across daily routines, eating, communication, regulation, safe community access, school-day sustainability and the protection of his informal supports. The package recommended below continues the two therapies that are working, adds the practical support layer the current plan lacks, and closes specific documented gaps with low-cost items. It is matched to the established pattern — prompt dependence, overload-driven safety risk, a narrow and static food range, communication that fails exactly when it is needed, and a household run as a continuous parent-delivered support system — and every element carries a review point.

Capacity Building — Improved Daily Living (Occupational Therapy)

Occupational therapy is recommended to continue at weekly frequency for 48 weeks, with a total allocation of 80 hours covering direct sessions, parent coaching, school liaison, resource development, travel, reporting and outcome measurement. Weekly intensity is warranted because the targets are active and several are escalating: the morning and self-care routines (a visual sequence with systematically faded prompts, worked in the home where the routine lives); mealtime tolerance through a structured food-chaining approach built outward from his accepted foods, with the iPad strategy retained until the skills exist to replace it; a shared home-and-school regulation plan aligned with the teacher's existing adjustments; graded community access, beginning with a specific carpark-and-road safety routine that converts his verbal knowledge into applied skill, and extending later to a supported return to swimming when he is ready; interoception work targeting the body signals — toilet, hunger, pain — whose absence runs through his health care and his regulation; a sleep and evening wind-down routine developed with his parents alongside the paediatrician's melatonin management; and assessment and trial of the assistive technology items below. The current allocation has supported regular therapy input; it has not provided capacity for the home-based routine work, parent coaching, school liaison and real-world generalisation this program requires, and the

recommended allocation reflects that broader functional program rather than a simple continuation of clinic-based sessions. Sessions should be delivered substantially in his real environments, and anchored to his interests — trains and puzzles are the entry points that work. Progress indicators are concrete: a measurable reduction in morning prompts, at least three new foods accepted and maintained, eating at the table with the family on most nights, the carpark routine used reliably, and COPM movement of two or more points on the prioritised goals. Mainstream health manages his eczema, growth and the ADHD review, and the school manages curriculum access; neither provides individualised functional capacity building in his home and community, and his parents are already implementing strategies at the limit of what informal support can carry. The value-for-money case is preventive: each target, achieved, directly reduces the daily support load and the risk pattern the rest of this report documents.

Capacity Building — Improved Daily Living (Speech Pathology)

Speech pathology is recommended to continue at fortnightly frequency for 48 weeks — approximately 24 sessions and a total allocation of 26 hours including parent coaching, teacher liaison and reporting. The first target should be a reliable help-and-break request usable at home and school, because it is the single highest-leverage skill in his profile: it interrupts the pathway to meltdown, gives the school an alternative to classroom exits, and gives Charlie his first tool for participating in his own safety. Further targets are negotiating changes to plans and routines, expanding functional language beyond scripts, and simple narrative and recount skills — telling what happened — which underpin his symptom reporting, his safety and his relationships. Visual supports should be maintained and aligned across home and school. Progress indicators: a help or break request used spontaneously in both settings, and simple "what happened" questions about his day answered without scripts. Curriculum literacy remains the school's responsibility; this is functional communication capacity, which the education system does not individually provide.

Core Supports — Assistance with Daily Life

Core support is recommended for the first time, at 4 hours per week for 12 months, delivered as two fixed blocks: one two-hour after-school block on a high-load weekday, supporting the after-school transition, regulation and the evening routine — the window where prompting demand peaks and meltdowns concentrate — and one two-hour weekend community-access block, practising the community, carpark and safety routines designed in occupational therapy in real settings, beginning from the outings that already work: the library, the park, the station mornings. The worker pool should be small and stable, introduced gradually through his interests, and explicitly briefed on his communication level, sensory profile and meltdown plan. The functional basis is established throughout this report: every routine is adult-delivered, supervision is continuous, the two-adult rule constrains all family outings, Jane has halved her employment to carry the load, no respite has ever been used, and Lucas is absorbing overflow at eleven. The support is deliberately dual-purpose — it builds Charlie's participation with a trained adult who is not also running the household, and it gives his family structured, predictable relief at the two costliest points of the week, protecting the informal system rather than replacing it. Four hours is the minimum that covers both pressure points; the family continues to provide everything else. This is disability-related support that substantially exceeds the support usually required by an eight-year-old, it is not the school's role or the health system's, and it represents value for money because it multiplies the funded therapy — generalising strategies into real routines — while preventing the carer-system deterioration that would cost far more to repair. Review at 12 months against concrete indicators: both blocks running with a consistent worker pool, the after-school routine completing with less parental takeover, at least one community venue added to his reliable range, and reduced carer strain on ZBI-12 re-administration.

Consumables

Continuation of the consumables allocation at approximately $550 per year: replacement chewable pendants, replacement ear-defender cushions, visual timetable and checklist printing

and laminating materials, and sand timers for transitions. These are inexpensive, already proven or directly tied to the strategies above, and require no formal review point.

Assistive Technology

Low-cost assistive technology up to $1,200 is recommended, assessed and trialled through the occupational therapy above: a correctly sized and weighted blanket, formalising the informally acquired item that is already central to his co-regulation routine; visual timers for the screen-to-task transitions that are his most reliable point of failure; and a second set of over-ear defenders for his school bag so that they are reliably available at school as well as at home. Each item addresses a documented sensory or executive impairment, sits well under complex-assessment thresholds, and should have trial outcomes documented by the treating occupational therapist.

Supports considered and not recommended

Behaviour support is not recommended at this stage. There is no self-injury, no aggression outside the meltdown context, no restrictive practice in use or contemplated, and his meltdowns are overload responses with identified triggers, appropriately addressed through the occupational therapy and speech pathology regulation-and-communication work above. If meltdown frequency or severity escalates, or aggression extends beyond the current bounded pattern, despite consistent implementation of the recommended supports over two school terms, a functional behaviour assessment should be reconsidered at that point.

Support coordination is not recommended. The plan is plan-managed, the parents are organised and engaged, the treating team is small and stable, and there have been no implementation failures; at this plan size, coordination would not represent value for money.

Psychology is not recommended at this time. There is no current anxiety or mood presentation requiring it. The position should be revisited at the ADHD diagnostic review, or earlier if anxiety or mood concerns emerge — an outcome worth watching for as his self-awareness grows.

NDIS-funded dietetics is not recommended at this stage. His weight is stable and his growth is monitored by his general practitioner; occupational-therapy-led food-chaining is the appropriate first-line response to the sensory basis of his restricted eating. This should be revisited if his centiles fall or his range narrows despite the OT program.

A transport budget is not recommended. Charlie travels by family car, the barrier is supervision and tolerance rather than transport cost, and the Core community block incorporates supported travel within activities.

Home modifications are not recommended. The home is single-storey and hazard-free; the gate lock was a minor parent-funded adjustment, and nothing structural is indicated.

Teacher-aide funding, curriculum support and tutoring remain the responsibility of the education system and are not sought from the NDIS; the plan's contribution to Charlie's schooling is the clinician liaison and the underlying regulation and communication capacity described above.

Specialist Disability Accommodation and Supported Independent Living are not indicated in any respect.

Summary of funding and value

The recommended package comprises occupational therapy at 80 hours over 48 weeks; speech pathology at 26 hours over 48 weeks; Core support at 4 hours per week for 12 months; approximately $550 per year in consumables; and up to $1,200 in low-cost assistive technology. It continues the therapy that is producing gains, adds the first practical support layer at the two points where the evidence shows the family system is most loaded, and closes documented sensory and safety gaps with inexpensive items. It is proportionate to the established impairments, targeted at the areas of greatest restriction — daily routines, eating, communication, safety and community access — and structured to reduce as capacity builds, with a review point attached to every element. It represents value for money because each component is priced against a specific, documented pattern whose continuation would cost

more: entrenched school avoidance, nutritional narrowing, preventable safety incidents and the breakdown of an informal support system that currently substitutes for far more expensive formal care. All of the recommended supports are most appropriately funded by the NDIS because they address the functional impact of permanent impairments, sit well beyond age-level expectations, and are not the responsibility of the health system or the school.

CHAPTER 18

Implementation Priorities, Review Points and Final Clinical Opinion

The immediate priorities are to establish the Core blocks well, to begin the most important early therapy work, and to avoid disrupting arrangements that are currently effective. In the first ninety days the Core worker should be recruited from a small, stable pool and introduced gradually — first meetings at home over trains and puzzles, with the after-school block beginning only once Charlie is comfortable — because a new adult in his routine is itself a demand, and a rotating roster would convert the support into another source of load. Occupational therapy should open with the carpark-and-road safety routine and the first stage of the mealtime program, and should finalise the shared regulation plan with the school early in the term. Speech pathology should make the help-and-break request its first and, if necessary, only initial target. Every provider entering his system should be briefed on the same point: Charlie's fluency about trains is not his functional language level, and overestimating his communication on first meeting is a predictable and avoidable error.

A three-month interim check should look for the help request emerging in at least one setting, the first new food holding in rotation, a falling count of morning prompts on the OT's baseline, both Core blocks established and tolerated, and a re-rating of the two or three most active COPM goals. Minimal movement at three months should prompt scrutiny of fit — session timing, worker match, whether the strategies are experienced as help or as further demand — before any thought of escalation.

From three to six months the work extends outward: the weekend block begins extending his range, trialling one busier venue at off-peak times using the OT-designed routines; the mealtime program aims for its second and third maintained foods and more shared family dinners; the sleep routine work beds in; and the school liaison confirms whether classroom exits are trending down as the help request takes hold. At six months the COPM should be formally repeated. Indicators of genuine progress are three new foods maintained, family

dinners shared most nights, the carpark routine reliable enough that his parents trust it, classroom exits reducing, and COPM movement of two or more points on the prioritised goals.

At twelve months, ahead of the next reassessment, the COPM, both SDQ forms, the Sleep Disturbance Scale for Children and the ZBI-12 should be repeated, with the Vineland-3 repeated at eighteen to twenty-four months rather than annually. The outcome of the ADHD diagnostic review should be incorporated: if the diagnosis is confirmed, therapy targets and any medical management — which remains the paediatrician's domain — will inform the next plan, and the position on psychology should be revisited at the same point. The package should then be adjusted to the evidence in either direction: not withdrawn because twelve months has elapsed if the functional picture has not shifted, and stepped down where capacity has genuinely built. A practical review indicator is the shape of Jane's week: if at twelve months she is still delivering every prompt, every routine and every recovery herself, the plan has not yet achieved its intended functional effect, and the response should be to revisit intensity and approach rather than to reduce support.

If these supports are not funded, the foreseeable consequences follow the documented pattern rather than speculation. The morning and evening routines remain wholly parent-delivered and the prompting load does not fall. The food range stays static at best, with nothing adding foods and ordinary attrition removing them. The carpark risk continues to be managed by supervision alone, with no growth in Charlie's own safety skill. The school pattern — exits, playground isolation, absence after poor nights — entrenches in the direction school avoidance takes. Jane's employment stays halved or reduces further, the couple's capacity continues to be spent entirely on logistics, and Lucas's role as auxiliary minder grows. These consequences are unlikely to present as a crisis within the year, but each compounds over time, and each is preventable at comparatively low cost now.

In my clinical opinion, Charlie presents with permanent impairments — Autism Spectrum Disorder Level 2 and a persistent mixed receptive-expressive language disorder, with ADHD under formal diagnostic review and not relied on here — that substantially reduce his functional

capacity compared with children of his age across communication, social interaction, learning, safe mobility, self-care and self-management. His presentation is defined by the gap between ability and application: average-range cognition and genuine strengths alongside adaptive functioning more than two standard deviations below age expectations, sustained across settings and informants and through four years of well-implemented intervention. His daily life functions because his parents deliver a continuous support system at documented cost to employment, sleep, family life and his brother's childhood, with no backup and no relief. The health system remains responsible for his medical care and the school for his educational adjustments, but neither addresses the disability-related needs documented here, which arise directly from his permanent impairments and are present across home, school and community. The recommended supports are specific, modest, matched to documented patterns, tied to measurable indicators and structured to reduce as capacity builds. They represent value for money because they are priced against a trajectory of widening gaps and wearing supports that is otherwise foreseeable, and in their absence Charlie's participation, his safety skills, his nutrition, his schooling and the sustainability of the informal supports around him are each likely to continue on the path this report has described.

SEEDS OCCUPATIONAL THERAPY

Standardised Assessment Results and Summary

Charlie John Citizen · Assessed July 2026

At a glance

VINELAND-3 · ADAPTIVE BEHAVIOR COMPOSITE

67

More than two standard deviations below the mean

Comprehensive Parent Interview, completed with Charlie's mother.

COPM · PERFORMANCE

3.0 / 10

Very low across priority goals

Mean across five goals identified with both parents.

COPM · SATISFACTION

2.4 / 10

Very low across priority goals

How satisfied his parents are with how these activities currently go.

In brief

— Adaptive functioning more than two standard deviations below age expectations, against average-range cognition.

— Identical behavioural elevations reported independently by home and school.

— Clinically significant sleep disturbance, and very low parent-rated performance on the goals that matter most to the family.

— Measurable carer strain, in the moderate range.

Detailed results for each measure follow on the next pages.

APPENDIX · STANDARDISED RESULTS

Vineland-3 — Adaptive Behavior

Vineland Adaptive Behavior Scales, Third Edition — Comprehensive Parent Interview, completed with Charlie's mother. Standard scores are reported for each domain and for the overall composite.

Domain	Standard score
Communication	**74**
Daily Living Skills	**63**
Socialisation	**65**
Adaptive Behavior Composite	**67**

The Adaptive Behavior Composite of 67 sits more than two standard deviations below the mean for his age. Daily Living Skills was his lowest domain; Communication was his relative strength and remains well below average.

APPENDIX · STANDARDISED RESULTS

Strengths and Difficulties Questionnaire

Completed independently by Charlie's mother and his classroom teacher.

Parent form

Subscale	Score
Emotional symptoms	5
Conduct problems	3
Hyperactivity	9
Peer problems	7
Prosocial behaviour	4
Total difficulties	**24**

Teacher form

Subscale	Score
Hyperactivity	8
Peer problems	7
Total difficulties	**21**

Total difficulties scores of 24 (parent) and 21 (teacher) both fall in the very high range. The elevated subscales are identical at home and school, and the low conduct scores in both settings are consistent with difficulties that are overload-driven rather than oppositional.

APPENDIX · STANDARDISED RESULTS

ADHD Rating Scale-5

Rated across the inattention and hyperactivity-impulsivity domains, in both settings.

Respondent	Result
Parent ratings	At or above the 93rd percentile
Teacher ratings	At or above the 90th percentile

These results are consistent with the developmental paediatrician's query and have been forwarded to inform the diagnostic review scheduled for the second half of 2026. No ADHD diagnosis has been made, and this report does not treat ADHD as confirmed.

APPENDIX · STANDARDISED RESULTS

Sleep Disturbance Scale for Children

Total sleep disturbance reported as a T-score.

SDSC · TOTAL

71 T-score

Clinical range

Total sleep disturbance across the scale.

The disorders of initiating and maintaining sleep subscale was the most elevated.

APPENDIX · STANDARDISED RESULTS

COPM — Canadian Occupational Performance Measure

Completed with both parents against their priority goals, each rated for importance, current performance and satisfaction out of ten.

PERFORMANCE · MEAN

3.0 / 10

Very low across priority goals

How well these activities are currently performed.

SATISFACTION · MEAN

2.4 / 10

Very low across priority goals

How satisfied his parents are with current performance.

Priority goal	Importance	Performance	Satisfaction
Managing the morning routine with fewer prompts	9	3	2
Broadening his food range and sharing family meals	9	2	2
Safe community outings, including carparks	10	3	2
Communicating his needs before reaching meltdown	8	3	3
Independence in bathing and tooth-brushing	7	4	3

A change of two or more points on re-administration is clinically significant. The COPM will serve as the primary review measure for this plan.

APPENDIX · STANDARDISED RESULTS

Zarit Burden Interview — Short Form (ZBI-12)

Completed by Charlie's mother.

ZBI-12 · TOTAL

24

Moderate range

Carer strain reported by Charlie's mother.

Endorsement concentrated on the strain of balancing Charlie's needs against her work and Lucas's needs, and on having insufficient time for herself.

Authorisation

This functional capacity assessment was prepared by the undersigned. The opinions expressed reflect my clinical judgement, based on the assessment activities and source material described in this report.

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Signed on 6 July 2026