Queensland Government

Gold Coast Health

COMMUNITY CHILD HEALTH REFERRAL

Facility: ______________________________

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

INSTRUCTIONS: Please ensure *BOTH pages* of the referral are completed AND that the parent / guardian completes the *CONSENT* section prior to forwarding the form via:

Fax to: 07 5687 9168 **OR** **Email:** child.health.intake@health.qld.gov.au

For further enquiries or information, please contact 07 5687 9183

Please note: Community Child Health routinely provide feedback to referrers regarding the outcome of the referral intake process. Appointment outcome feedback may be provided to referrers, where appropriate, **with the consent** of the parent / guardian following the child's appointment with Community Child Health.

CLIENT DETAILS (please use a separate referral form for EACH relevant child in the family)

Family name: ______________________ **First name:** ______________________ **Sex:** ☐ Male ☐ Female

DOB: _____/_____/_____ Age: ______ years ______months Gestation: (if applicable / known) ______________________

Address: ____

Indigenous Status: ☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal NOT Torres Strait Islander ☐ Australian South Sea Islander ☐ Non Indigenous

Language: ☐ English ☐ Other – Specify: __________________ Interpreter required: ☐ No ☐ Yes

Country of birth: ________________________________ **Religion:** ________________________________

Medicare number: ________________________________ **Reference No:** __________ **Valid to:** _______________

Parent / Guardian name: ____

Relationship to client: ____________________________ **Preferred contact number:** ________________________

Parent / Guardian email: ____

REASON FOR REFERRAL (please tick appropriate boxes to provide further information over page as required)

☐ ***Neonatal / Postnatal concerns:***

☐ Infant complications ☐ Maternal complications ☐ Newborn feeding / nutrition

☐ Other – Specify: ____

☐ ***Child Development:***

☐ General assessment ☐ Speech / language ☐ Gross motor ☐ Fine motor / vision ☐ ASD

☐ Other – Specify: ____

☐ ***Child Behaviour / Parenting concerns:***

☐ Sleep / settling ☐ General behaviour ☐ Bedwetting ☐ Social development

☐ Other – Specify: ____

☐ ***Hearing Health Assessment – 4 years and older*** ☐ ***General nutrition / feeding issues***

☐ ***Youth Health concerns:***

☐ Medical issues/complications ☐ Mental health ☐ Substance misuse

☐ Other – Specify: ____

☐ ***Social concerns:***

☐ Domestic / family violence ☐ Mental health ☐ Financial stress ☐ Substance misuse

☐ Other – Specify: ____

Any known risks to professionals home visiting? ☐ No ☐ Yes - Specify: __________________

____

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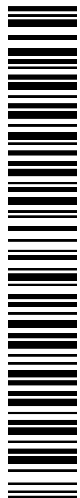
All clinical form creation and amendments must be conducted through Health Information Services
Date Reviewed – 04/2018



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COMMUNITY CHILD HEALTH REFERRAL

Gold Coast Health

COMMUNITY CHILD HEALTH REFERRAL

Facility: ____________________________________

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

ADDITIONAL REFERRAL DETAILS

Additional information / referral reason: ☐ No ☐ Yes – Specify below:

Previous Medical History:

☐ Unknown ☐ Nil ☐ Yes – specify below

Allergies:

☐ Unknown ☐ Nil ☐ Yes – specify below

Medications:

☐ Unknown ☐ Nil ☐ Yes – specify below

Previous Screening / Investigations:

☐ Unknown ☐ Nil ☐ Yes – indicate below AND attach copy if available:

Other Agency / Services involved	Contact person	Contact number

CONSENT TO REFERRAL

Parent / Guardian name: ____________________________________

Relationship to client: ____________________________________

Signature: ______________________________ Date: _____/_____/_____

REFERRERS DETAILS

Referrers name: ______________________________ Designation: ____________________

Signature: ______________________________ Date: _____/_____/_____

Referring Agency / Service: ____________________________________

Provider Number: __________________________ (if applicable) Contact number: __________________________

Email: ____________________________________

For Medical Officers only: Named referral to Dr: ______________________________ ☐ No ☐ Yes

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