CENTRE FOR ADOLESCENT HEALTH

REFERRAL FORM

Send to: William Buckland House
2 Gatehouse St
Parkville VIC 3052
Fax: +61 3 9345 6343
Phone: +61 3 9345 5890
Website: www.rch.org.au/cah

Young person's name: ______________________________

Address / Contact details: ______________________________

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Parents / Carers details: ______________________________

Date of Birth: __________ Age: ______ Medicare number: ______________________________

Language spoken at home: ______________________ Interpreter required: ☐ Yes ☐ No

Issues of concern

☐ General adol. medicine ☐ Mood / Anxiety ☐ Sexual development ☐ Gynaecological
☐ Chronic illness ☐ Behaviour ☐ Family system ☐ Other
☐ Physical development ☐ School issues ADHD ☐ Yes ☐ No ______________

Detailed summary of concerns ______________________________

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Relevant past history ______________________________

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Current management

Medications ______________________________

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Other health/school professionals? ______________________________

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If Eating Disorder (including obesity) please provide the following information:

Max weight ________ kg Date __________ Heart rate ______________________________

Min weight ________ kg Date __________ Blood pressure ______________________________

Current weight __________ kg Amenorrhea ☐ Yes ☐ No

Services requested of Adolescent Health

☐ Assessment ☐ Adolescent Forensic Health Service ☐ Chronic Illness Peer Support
☐ Ongoing management ☐ AFHS – Juvenile justice referral ☐ Other
☐ Mental Health

Date of referral: ______________________

Referred by: ______________________

Doctor's signature:______________________

RCH dept: ______________________

Provider stamp

Provider number:

Address:

Referral duration: ☐ 3 months ☐ 12 months ☐ Indefinite ☐ Other __________

Urgency of referral: ☐ Urgent ☐ Semi-urgent ☐ Non-urgent