EASTERN METROPOLITAN REGION
SPECIALIST CHILDREN'S SERVICES
Referral Form

State Government Victoria — Department of Human Services

Note: Parental consent must be gained prior to submitting this form. All information will remain confidential

CHILD'S INFORMATION

DATE:

SURNAME: ..... **Given Name:** .....

Date of Birth: ..... **Age:** ..... **F / M**

Address: .....

..... **Postcode** .....

Country Of Birth: **Local Government Authority:**

PARENT/GUARDIAN INFORMATION

MOTHER'S SURNAME: ..... **Given Name:** .....

Address: .....

..... **Postcode:** .....

Phone *(Private):* ..... ***(Business):*** ..... ***(Mobile):*** .....

Country of Birth:

FATHER'S SURNAME: ..... **Given Name:** .....

Address: .....

..... **Postcode:** .....

Phone *(Private):* ..... ***(Business):*** ..... ***(Mobile):*** .....

Country of Birth:

Name of primary caregiver: ..... **Relationship to child:** .....

Languages Spoken at Home: ..... **Interpreter Required:** **Yes** **No**

Best time/day of the week to call:

Koorie / TSI	Yes/No	**Family Health Card:**	Yes/No	**Carer's Allowance**	Yes/No Applied For

BRIEF DESCRIPTION OF CHILD'S NEEDS/REASONS FOR CONCERN/DIAGNOSIS: **Please give details and examples *eg fine/gross motor, behaviour, social/emotional, speech/language, feeding/diet, other:***

Please attach any relevant reports.

.....

.....

.....

.....

.....

.....

SERVICES REQUESTED:

VISION:	Formal Testing	Yes ☐	No ☐	Date:
HEARING:	Formal Testing	Yes ☐	No ☐	Date:
Any Concerns:				

RELEVANT FAMILY INFORMATION: **(eg family history of developmental problems, stress factors, illness, etc.)**

Has your child been seen by anyone in relation to your concerns about his/her problem (eg GP, paediatrician, medical specialist, or therapists)? Please provide details:

Name	Profession	Phone Number	When Last Seen	Next appt

Does your child attend childcare, play group, early intervention program or preschool?

Name of Centre	Address	Phone	Contact Person

PERSON REFERRING:

NAME: _____

Position: _____ **Telephone No:** _____

Centre Name: _____ **Fax Number:** _____

Postal Address: _____

_____ **Postcode** _____

Referral Taken By: **Date:**

OTHER EI SERVICES/AGENCIES FAMILY ALREADY REFERRED TO:

Agency	Date	Contact Person

PARENTAL/GUARDIAN CONSENT

I agree to the above information being used for referral to Specialist Children's Services, Eastern Region and for that service to make contact with the referrer to discuss the referral. I understand that the above information will be recorded on the Department of Human Services databases for the purposes of service planning.

Signature: _____ **Verbal Consent:** ☐

Privacy Statement: Family information will be collected and shared only with parent/caregiver consent. The information on this referral form will be kept ONLY by Specialist Children's Services, to whom the child has been referred. It will be kept in a confidential, secure place. The child's parents/guardians may request access to this referral form.

Please return completed form to: **Intake Worker, Specialist Children's Services, Department of Human Services, Locked Bag 2015, Box Hill 3128**