

Developmental Care Referral Form

Essential fields denoted with *

1. Referrer information

*Date:	*Name:	*Surname:		
*Provider number:	*Practice address:			
*Practice name:	*GP	*Paediatrician	*Other (profession):	
*Telephone:	*Fax:	*Email:		

2. Background referral information

*Is this a new referral or continuation of an existing referral?	New	Existing	
*Is this a referral to see the same doctor as a sibling?	Yes	No	
*Name sibling's RCH doctor:			
*Has this referral been proposed by someone other than yourself?	Yes	No	
Family requesting a second opinion	Pre-school field officer	Maternal and child health nurse	
Allied Health (please specify):	Kinder	School	Unknown

Please enclose any relevant correspondence

3. Child/Adolescent information

*Surname:	*First name:			
*Gender:	*DOB:	Current age:		
*Address:				
*Suburb:		*Post code:		
*Medicare eligible:	Yes	No	*Medicare number:	
*Is this child of:	Aboriginal origin	Torres Strait Islander origin	Neither	Unknown
*Did this family arrive as a refugee or asylum seeker?	Yes	No	Country:	
*Is an interpreter required?	Yes	No	Language:	
*Does this child:	Live with parents	Live with others (please provide details):		
*Is this child known to Child Protection Services?	Yes	No		
Name/Contact details:				
*Are there any current court orders for this child or family?	Yes	No		
Details:				
*Are there any other medical/social/mental health /access complexities for this family?				
*Is the child accessing NDIS?	Referred	Accessed	No	

4. Parent/Guardian information

*Primary contact: Mother Father Legal guardian	Title: Mr Mrs Ms Miss
*Surname:	*First Name:
*Address:	*Suburb: *Postcode:
Home phone:	* Mobile phone:
*Email:	Prefered contact method:
*Parent/Guardian consent for this referral: Yes No	

5. Reason for referral

*Please detail relevant health history including any confirmed developmental diagnoses:

*What outcome are you wanting from this child's referral?	Assessment/Diagnosis			
Treatment plan/Advice on management strategies	Ongoing intervention	Shared care	Transfer of care	
*Please identify ALL areas of developmental concern				
Physical development/motor skills	Speech	Language	Play skills	Behaviour/Emotion
Functional skills (meal times, toileting, dressing)	Social skills	Attention/Concentration	Hyperactivity	
Learning/Academic performance	Developmental regression	Feeding/Eating/Diet	Sleep	Other

*Please provide relevant background details for each area in the space provided:

6. Services and reports

*Is this child known to another health service? Yes No

*Name of service/Condition treated:

*Are there other professionals currently or previously involved with this child and family?

Profession	Name/Facility	Active/Inactive		Report attached	
		Active	Inactive	Yes	No
General practitioner		Active	Inactive	Yes	No
Paediatrician		Active	Inactive	Yes	No
Occupational therapist		Active	Inactive	Yes	No
Speech pathologist		Active	Inactive	Yes	No
Physiotherapist		Active	Inactive	Yes	No
Maternal and child health nurse		Active	Inactive	Yes	No
Day Care/Kinder/School		Active	Inactive	Yes	No
Audiologist		Active	Inactive	Yes	No
Optometrist		Active	Inactive	Yes	No
Psychologist		Active	Inactive	Yes	No
Key worker		Active	Inactive	Yes	No
Other		Active	Inactive	Yes	No

*Parent/Guardian consent for RCH to contact other service providers involved: Yes No

7. Signature

Name:

Date:

*Signature:

* Referral Duration:

3 months

12 months

Please fax completed referral form to: (03) 9345 5034

Thank-you for your referral.

For more information please call the the RCH Developmental Intake Team on **(03) 9345 4631** or email **developmentalintake@rch.org.au**

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