The Royal **Children's** Hospital Melbourne

UR NUMBER

SURNAME

GIVEN NAME(S)

DATE OF BIRTH

AFFIX PATIENT LABEL HERE ↑

Allied Health Referral

Date ____ / ____ / ____

◯ **Inpatient** ◯ **Outpatient** **Ward/Clinic** _____

Unit _____ **Consultant** _____

Discipline required: *(please tick)*

◯ **Physiotherapy** ◯ **Occupational Therapy** ◯ **Speech Pathology** ◯ **Orthotics/Prosthetics**

◯ **Educational Play Therapy** ◯ **Music Therapy** ◯ **Dietetics**

◯ **Audiology** *(see below)*

AUDIOLOGY ONLY

Gestational age if <8 months _____

Clinical details ◯ Standard patient ◯ Complex patient

◯ Developmental delay

◯ Syndrome

◯ Behavioural problems

◯ Other disabilities _____

_____

Provider number _____

Referral for ◯ 3 months ◯ 12 months

For Social Work referrals *please contact the relevant social workers or contact 9345 6111*

Diagnosis/history _____

_____

_____

_____

_____

Reason for referral _____

_____

_____

Referrer name _____ **Phone/pager** _____

Referrer signature _____

Please forward referrals to *SCB/Allied Health, Level 1, East Building or email alliedhealth.admin@rch.org.au Enquiries 9345 9300*

Orthotics *(office use only)*

Item						**Q**	

Job number

Order date ____ / ____ / ____

Finish date ____ / ____ / ____

Measured by

RCH Invoice receipt _____

ERC 11870 November 2011 Stock number 30681