Developmental Care Referral Form

The Royal Children's Hospital Melbourne

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

2000091 June 2020

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
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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