VICTORIAN ABORIGINAL HEALTH SERVICE CO-OPERATIVE LTD.

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REFERRAL FORM TO VAHS PAEDIATRIC SERVICE for:

External providers

Email referral to: paediatricreferrals@vahs.org.au

Date of referral __ /__ /____

CLIENT DETAILS **Aboriginal** □ **Torres Strait Is** □ **Both** □

Family Name _____

Given Name(s) _____ Other Name(s) / Preferred Name(s) _____

DOB: ___ / ____/ _____ Gender:_____

Current Address: _____ Suburb: _____P/Code: _____

Phone _____ Mobile _____

REFERRER DETAILS

Name: _____

Position: _____ Service/Agency: _____

Address: _____ Suburb: _____ ___P/Code: _____

Direct phone: _____ Mobile: _____ Preferred contact: _____

Email Address: _____

PARENT 1 **Aboriginal** □ **Torres Strait Is** □ **Both** □	**PARENT 2** **Aboriginal** □ **Torres Strait Is** □ **Both** □
Name _____	Name _____
Address: _____	Address: _____
Suburb: _____ ___P/Code: _____	Suburb: _____ ___P/Code: _____

Last updated: 09/09/21

Ph Home _____Ph Mobile _____ Email (optional): _____	Ph Home _____Ph Mobile _____ Email (optional): _____

LEGAL GUARDIAN

Who is the child's legal guardian? □ Mother □ Father □ Both □ Other Aboriginal □ Torres Strait Is □ Both □

If other, Relationship: _____ _____ Name: _____

Ph Home _____ Ph Mobile _____ Email: _____

COURT ORDERS IN PLACE

Are there any court orders in place in relation to this child Yes □ No □ If yes,

Type of order: _____ expiry date of order : ___ / ____/ _____

Relevant details of order:_____

_____

_____

PRIMARY OR ALTERNATIVE CONTACT PERSON FOR THIS CLIENT (IF DIFFERENT TO LEGAL GUARDIAN) (e.g. if VAHS wished to arrange an appointment)

Name: _____ Relationship: _____
Service/Agency (if applicable): _____

Address: _____ Suburb: _____ ___P/Code: _____

Direct phone: _____ Mobile: _____ Preferred contact: _____

Email Address: _____

PROFESSIONALS / AGENCIES / SERVICE PROVIDERS INVOLVED

Name: _____ _ Agency: _____ _____ _____ Role: _____ _____ ____	Name: _____ _ Agency: _____ _____ _____ Role: _____ _____ ____

Address _____ _____ Ph Work _____ Ph Mobile _____ **Email:** _____	Address _____ _____ Ph Work _____ Ph Mobile _____ **Email:** _____

SCHOOL / KINDERGARTEN / CHILD CARE

Does the client go to school / kindergarten / childcare? □ Yes □ No

Name of School / Kindergarten / Child Care: _____ Grade / Year (if applicable): ____

Address: _____ Suburb: _____ ___P/Code: _____

Contact Person _____ Ph Work: _____ Ph Mobile: _____

Email: _____

REASON FOR REFERRAL

VAHS offers many services to Children and Young People. To provide the client with the most appropriate service, it is useful for VAHS to know your specific concerns in regards to the client's health and or development.

DO YOU HAVE A SPECIFIC CONCERN(S) REGARDING THE CLIENT'S HEALTH OR WELLBEING THAT YOU WISH VAHS TO ASSESS OR ADDRESS? □ Yes □ No If yes, please outline below:

_____

_____

_____

_____

_____

_____

_____

_____

OTHER SPECIFIC CONCERNS

Are you concerned about any of the following (tick all appropriate)

□ Motor Development (e.g. rolling, crawling, walking) □ Speech Development □ Hearing

□ Behaviour □ Learning □ Intellectual Disability □ Mental Health

□ Immunisation □ Dental Health

□ Drug and Alcohol issues □ Puberty □ Sexual and Reproductive health

Please note that whilst the VAHS paediatric service does see many children with behavioural and developmental needs it does not provide urgent mental health assessment. Please refer to the referral guide below if there are acute mental health concerns.

Has the Client had any of the following:

Referral to NDIS: □ Yes □ No Date: _____

Hearing check: □ Yes □ No Date: _____ Location: _____

Dental review: □ Yes □ No Date: _____ Location: _____

For VAHS clients: Child Health Check □ Yes □ No

PAST MEDICAL HISTORY

Does the Client have any medical diagnosis or condition that you know of? □ Yes □ No

If yes, please list below including any previous assessments the provider name and service:

_____

_____

_____

_____

_____

MEDICATION

Is the Client currently on any medication? □ Yes □ No If yes, please list below:

_____

_____

_____

OTHER INFORMATION

Is there any other information that you think is important for us to know about this client or family?

_____

_____

_____

_____

_____

PLEASE PROVIDE COPIES OF ANY DOCUMENTATION, PREVIOUS ASSESSMENTS, SCHOOL REPORTS ETC. THAT MAY ASSIST IN PROVIDING CARE FOR THIS CLIENT

(ADMIN USE ONLY)

Intake Meeting- date discussed ___ / ___ / _____ Allocated Health Worker ____ _____

Allocated services (s) and clinician _____

Appointment date ___ / ___ / _____ Appointment letter sent ___ / ___ / _____

Other internal referrals

□ Child Health Check □ Dental □ Koori Kids □ Parenting Program □ General Practitioner

□ Paediatrician □ MCHN □ Optometry □ Audiology □ Speech

□ Other _____