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|   | **VICTORIAN ABORIGINAL HEALTH SERVICE CO-OPERATIVE LTD.**ABN 51 825 578 859186 Nicholson St, Fitzroy, Victoria 3065 Ph: (03) 9419 3000 Fax: (03) 9419 1208 |

**REFERRAL FORM TO VAHS PAEDIATRIC SERVICE for:**

 **External providers**

**Email referral to: paediatricreferrals@vahs.org.au**

**Date of referral:** Click or tap to enter a date.­

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| **CLIENT DETAILS Aboriginal** [ ]  **Torres Strait Is** [ ]  **Both** [ ] **Family Name** ­­­ **Given Name(s)**  **Other Name(s) / Preferred Name(s**) ­­­ **DOB:**Click or tap to enter a date. **Gender**: Choose an item.**Current Address:** **Suburb** **P/Code** **Phone** **Mobile**  |

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| **REFERRER DETAILS****Name:** **Position:** **Service/Agency:** **Address:**   **Suburb:** **P/Code** **Phone:** **Preferred contact**: Choose an item.**Email Address**:  |
| **PARENT 1 Aborigin** [ ]  **al Torres Strait Is** [ ]  **Both** [ ]  **Name:** **Address:**  **Suburb:**  **P/Code:**  **Ph Home:** **Ph Mobile:** **Email (optional):**  | **PARENT 2 Aboriginal** [ ]  **Torres Strait Is** [ ]  **Both** [ ]  **Name:** **Address:** **Suburb:**  **P/Code:** **Ph Home:** **Ph Mobile:** **Email (optional):**  |

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| **LEGAL GUARDIAN** **Who is the child’s legal guardian?** [ ]  Mother [ ]  Father [ ]  Both [ ]  Other **If other, Relationship:**  **Name:** **Ph Home:**  **Ph Mobile:** **Email:**  |

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| **COURT ORDERS IN PLACE****Are there any court orders in place in relation to this child**: Yes [ ]  No [ ]  If yes, **Type of order:** **Order Expiry date:** Click or tap to enter a date. **Relevant details of order:**   |

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| **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**

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| **Name:** **Agency:** **Role:** **Address:** **Ph Work:** **Ph Mobile:** **Email:**  | **Name:** **Agency:** **Role:**  **Address:** **Ph Work:** **Ph Mobile:** **Email:**   |

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| **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.*

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| **DO YOU HAVE A SPECIFIC CONCERN(S) REGARDING THE CLIENT’S HEALTH OR WELLBEING THAT YOU WISH VAHS TO ASSESS OR ADDRESS?**   |

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| **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 (Specify: )[ ]  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.***

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| **Has the Client had any of the following:** |
| **Referral to NDIS:** [ ]  Yes [ ]  No Date: Click or tap to enter a date.**Hearing check:** [ ]  Yes [ ]  No Date: Click or tap to enter a date.Location: Dental review: [ ]  Yes [ ]  No Date: Click or tap to enter a date. |

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| **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:**  |

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| **MEDICATION** **Is the Client currently on any medication?** [ ]  Yes [ ]  No If yes, please list below (including dose):   |

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| **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**

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|  ***(ADMIN USE ONLY)***Intake Meeting- date discussed Click or tap to enter a date. Allocated Health Worker Allocated services (s) and clinician Appointment date Click or tap to enter a date. Appointment letter sent Click or tap to enter a date.Other internal referrals[ ]  Child Health Check [ ]  Dental [ ]  Koori Kids [ ]  Parenting Program [ ]  General Practitioner [ ]  Paediatrician [ ]  MCHN [ ]  Optometry [ ]  Audiology [ ]  Speech [ ]  Other  |