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|  | **VICTORIAN ABORIGINAL HEALTH SERVICE CO-OPERATIVE LTD.**  ABN 51 825 578 859  186 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 |