



VICTORIAN ABORIGINAL HEALTH SERVICE CO-OPERATIVE LTD.

ABN 51 825 578 859
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PAEDIATRIC REFERRAL (External Providers)

PLEASE NOTE: Confirmation of Aboriginality (COA) is required prior to referral (VAHS does not provide services to obtain COA). Patients without a COA will not be able to access VAHS paediatric services.

Email referral to: paediatricreferrals@vahs.org.au

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

CLIENT DETAILS		☐ Aboriginal	☐ Torres Strait Is	☐ Both
Family Name				
Given Name(s)		Other Name(s) / Preferred Name(s)		
DOB:		Gender: Prefer Not To Answer		
Current Address:		Suburb:		P/Code
Phone		Mobile		

REFERRER DETAILS				
Name:				
Position:		Service/Agency:		
Address:		Suburb:		P/Code
Phone:		Preferred contact:		
Email Address:				

PROFESSIONALS / AGENCIES / SERVICE PROVIDERS INVOLVED

Name:	Name:
Agency:	Agency:
Role:	Role:
Address:	Address:
Ph Work: Ph Mobile:	Ph Work: Ph Mobile:
Email:	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?**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.

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:	

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 (including dose):

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