South West Healthcare

CHILD HEALTH AND DEVELOPMENT TEAM: REFERRAL FORM

UR NO:
SURNAME:
GIVEN NAME:
DOB:
ATTACH LABEL IF AVAILABLE

Type directly into form or print and fill manually
Email completed form to intake@swh.net.au **OR**
Send forms to: Community Health Intake, South West Healthcare, Ryot St, Warrnambool, 3280.
Phone: 5563 4000 Fax: 5563 1669

GENERAL INFORMATION	**Date of Referral:**
Child' Full Name:	Date of Birth:
Male ☐ Female ☐ Indeterminate ☐ Other ☐ Is there anything else you'd like us to know about your child's gender?	
Parent/Carer 1 Full Name:	
Address:	
Phone:	Email:
Parent/Carer 2 Full Name:	
Address:	
Phone:	Email:
Do you consent to contact via email? Yes ☐ No ☐	Indigenous Status: Aboriginal ☐ Torres Strait Islander ☐ Neither ☐ Declined to Answer ☐
Languages spoken at home:	Do you need an interpreter? Yes ☐ No ☐ Language:

Other services your child visits:	**Service name and your key contact**	**Permission to share information, please tick:**
Family Doctor (GP)		☐
Maternal and Child Health Nurse		☐
Paediatrician		☐
Child Care Centre		☐
Kindergarten/School		☐
Family Support Worker (e.g. Child First, Mpower, Council)		☐
Early Childhood Intervention Services (e.g. Mpower, Private Therapists)		☐

Please describe areas of concern (complete all relevant areas):

Physical Development (e.g. posture, muscle tone, muscles/joint issues, neurological signs, hip dysplasia)

Motor Skill Development (e.g. rolling, sitting, crawling, walking, balance, coordination, pencil control, scissor use)

Communication (e.g. understanding language/instructions, vocabulary, clarity of speech, stuttering/fluency)

Eating and Drinking skills (e.g. swallowing difficulties, gagging/coughing when eating or drinking, difficulty transitioning to solids)

Nutrition (e.g. allergies, adequacy of diet, growth)

Play / Cognition / Social Interaction (e.g. interaction with others, sharing, turn-taking, pretend play, learning, remembering and practising new skills)

Behaviour / Attention / Managing emotions / Sensory (e.g. distractible, impulsive, inattentive, tantrums, following rules, cooperation, easily upset, excessive crying, sensory seeking or avoidance behaviours)

Parent/Guardian Consent

The information I have provided on this form is true and accurate. I consent to my son/daughter/child under my guardianship being referred for services at South West Healthcare. I give permission for the Child Health and Development staff at South West Healthcare to share information regarding my son/daughter/child under my guardianship, with staff from the agencies listed above.

Signed (parent/guardian) Date:

OR Referrer Record of Parent/ Guardian's Verbal Consent

I have discussed the proposed referral with the child's parent/guardian, and I am satisfied that they understand the purpose of the referral, and that they have provided their informed consent:

Yes ☐ **No** ☐

Name: Date:

PRIVACY STATEMENT: The information on this form has been collected for the purpose of supporting your child. The information will not be disclosed to any other party except as required by law, or if you have given consent above. You can change or correct the information by contacting the service.