

Referral Guidelines

1. Please complete all sections of this form and return to Central Referral Service via email to **WSLHD-CommunityHealth-ReferralService@health.nsw.gov.au**
2. Alternatively, referrals can be faxed to **9881 7789**
3. Sections marked with an asterisk (*) are mandatory fields.
4. For enquiries, please phone **1800 600 681**

Client Information

Given Name(s)*:

Family Name*:

Address*:

Suburb*:

Postcode*:

Medicare No.*:

Date of Birth*:

Sex*: Male Female

Home Phone*:

Mobile Phone:

Email Address:

Country of Birth:

Interpreter required*: Yes No

Preferred Language:

Has the client consented to this referral*: Yes No

Does the client consent to receive SMS appointment reminders*: Yes No

Is the client Aboriginal or Torres Strait Islander?*

- No
 Yes – Aboriginal
 Yes – Torres Strait Islander
 Yes – Both Aboriginal and Torres Strait Islander
 Declined to respond
 Unknown

Is the child on the Out of Home Care Health Pathway?*

Yes No N/A

Is the child currently accessing NDIS / ECEI services?

Yes No N/A
Details

Reason for Referral

Referral Type:

- Child & Family Health Nursing
 Audiometry
 Occupational Therapy
 Speech Pathology
 Counselling

Description of presenting issue and or treatment requested*

Please detail any relevant diagnosis or previous assessment/treatment

Please attach any relevant assessment documentation such as maternal/infant assessments, outcomes assessments, psychosocial screening, ASQ, School counsellor reports, Paediatrician report, etc.

PARENT / CARER DETAILS

PRIMARY PARENT / CARER DETAILS *:

Given Name(s)*:	Family Name*:
Address*:	
Relationship*:	
Contact Phone Number*:	Residency Status: <input type="checkbox"/> Resident <input type="checkbox"/> Non Resident
Language spoken:	Interpreter required? <input type="checkbox"/> Yes <input type="checkbox"/> No

OTHER PARENT / CARER (if applicable)

Given Name(s):	Family Name:
Address:	
Contact Phone Number:	Residency Status: <input type="checkbox"/> Resident <input type="checkbox"/> Non Resident
Relationship:	
Language spoken:	Interpreter required? <input type="checkbox"/> Yes <input type="checkbox"/> No

PERSON TO CONTACT DETAILS

Tick if as above, or complete section below*

Given Name(s):	Family Name:
Address:	
Relationship:	
Contact Phone Number:	Residency Status: <input type="checkbox"/> Resident <input type="checkbox"/> Non Resident
Language spoken:	Interpreter required? <input type="checkbox"/> Yes <input type="checkbox"/> No

GP DETAILS

Name:	Telephone:	Fax:
Email:		
Practice Name and Address:		

SCHOOL / CHILD CARE DETAILS

Name of school / pre-school / child care:	Telephone:
School year:	

Referrer Details *

Referral Date:	Referrer Name:
Referrer Phone:	Referrer Organisation: (if a hospital please state ward:)
Referrer Email:	

OFFICE USE ONLY:

Date received:	Date reviewed:
Actioned By:	



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