Child and Family Health - Referral Form

NSW GOVERNMENT Health Western Sydney Local Health District

Child & Family Health Services

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.*

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PARENT / CARER DETAILS

PRIMARY PARENT / CARER DETAILS *:

Given Name(s)*:	Family Name*:
Address*:	
Relationship*:	
Contact Phone Number*:	Residency Status: ☐ Resident ☐ Non Resident
Language spoken:	Interpreter required? ☐ Yes ☐ No

OTHER PARENT / CARER (*if applicable*)

Given Name(s):	Family Name:
Address:	
Contact Phone Number:	Residency Status: ☐ Resident ☐ Non Resident
Relationship:	
Language spoken:	Interpreter required? ☐ Yes ☐ 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: ☐ Resident ☐ Non Resident
Language spoken:	Interpreter required? ☐ Yes ☐ 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:	