

# Gippsland Lakes Complete Health Paediatric Allied Health Referral Form



## About this form

The information provided on the form will assist us to get to know your child so that we can coordinate your services. If you need help to complete the referral form, please contact our intake team on 5155 8367.

## Details of person completing referral

<b>Name of referrer</b>	<b>Relationship to child</b>		
<b>Referrer phone</b>	<b>Referrer email</b>		
<b>Service (if relevant)</b>	<b>Service phone/email</b>		
<b>Other referrals completed (eg Paediatrician, NDIS, early help, Integrated Family Services, orange door):</b>			
<b>Would this family benefit from a keyworker referral</b>	<b>Yes</b>	<b>No</b>	<b>Unsure</b>
<b>Please inform the referrer if unable to contact</b>	<b>Yes</b>	<b>No</b>	

## Child details

<b>Child's first name</b>	<b>Child's surname</b>		
<b>Gender</b>	<b>Date of birth</b>		
<b>Address</b>			
<b>Country of birth</b>	<b>Interpreter required</b>	<b>Yes</b>	<b>No</b>
<b>Language spoken at home</b>			

## Parent/carer contact details

<b>Carer 1 Full name</b>		<b>Carer 2 Full name</b>	
<b>Relationship to child</b>		<b>Relationship to child</b>	
<b>Phone</b>		<b>Phone</b>	
<b>Email</b>		<b>Email</b>	
<b>Interpreter required</b>	<b>Yes</b>	<b>No</b>	<b>Interpreter required</b>
			<b>Yes</b>
			<b>No</b>
<b>Language</b>		<b>Language</b>	
<b>Are there any family court orders regarding this child</b>		<b>Yes</b>	<b>(please provide details)</b>
			<b>No</b>
<b>Living arrangements if living between carers</b>			

## Referral details

<b>Referral for</b>	<b>Occupational Therapy</b>	<b>Speech Pathology</b>	<b>Physiotherapy</b>
<b>Feeding clinic</b>	<b>Plagio/ Torticollis clinic</b>	<b>Autism clinic (requires paediatrician referral)</b>	

## Reason for referral (attach any relevant reports/letter to provide us with all relevant information)

**Child's strengths/interests**

**Reason for referral (what is your child having difficulties with)**

**Developmental concerns**

Gross motor (whole body movements)	Play/social skills
Fine motor/handwriting	Sensory processing
Self-care	Emotional regulation
Speech development	Language development
Other	

Birth history						
<b>Born at</b>	<b>weeks</b>	<b>Birth weight</b>				
For children born more than 4 weeks early please provide estimated due date						
<b>Mode of delivery</b> (vaginal, planned caesarean, unplanned caesarean)						
<b>Location of delivery</b> (home birth, local hospital, tertiary service)						
<b>Was your child exposed to medication or alcohol during pregnancy?</b>						
<b>Medication exposure</b>	<b>Yes</b>	<b>No</b>	<b>Unsure</b>	<b>Alcohol exposure</b>	<b>Yes</b>	<b>No</b> <b>Unsure</b>
<b>Were there any complications during or just after the birth</b> (e.g. Special care nursery, oxygen, tube feeding, APGAR score, referrals post hospital discharge). Please provide details						

Medical history		
<b>Formal diagnosis/relevant medical information</b>		
<b>Allergies</b>		
<b>My child has had a hearing check</b>	<b>Date</b>	<b>Outcome</b>
<b>Yes</b> <b>No</b>		
<b>My child has had a vision assessment</b>	<b>Date</b>	<b>Outcome</b>
<b>Yes</b> <b>No</b>		
It is recommended that all children have had a hearing and vision assessment prior to attending allied health services.		

Professionals/services Please provide details of other services involved with your child		
<b>General practitioner</b>	Name	Clinic
<b>Paediatrician</b>	Name	Clinic
<b>Education (school, childcare, kinder)</b>	Name	Year level / days attended
<b>Other services (Maternal &amp; Child Health Nurse, Ear Nose &amp; Throat, Allied health professionals, NDIS, tertiary hospitals, Early Help, Orange Door, Integrated Family Services)</b>	Service name	Contact
	Service name	Contact

Child is starting school in the next 12 months	<b>Yes</b>	<b>No</b>	<b>Name of School</b>
Child is in Out of Home Care	<b>Yes</b>	<b>No</b>	
Aboriginal or Torres Strait Islander	<b>Yes</b>	<b>No</b>	

Other relevant information			
Is there any history of family violence?	<b>Yes</b>	<b>No</b>	<b>Unsure</b>
Are there any family relationship issues that may be affecting your child?	<b>Yes</b>	<b>No</b>	<b>Unsure</b>
Any stressors/barriers to attendance (eg. method of contact, transport, financial, work)?	<b>Yes</b>	<b>No</b>	
<b>Details</b>			
<b>Availabilities for appointments (check boxes)</b>			
<b>Monday</b>	<b>Tuesday</b>	<b>Wednesday</b>	<b>Thursday</b> <b>Friday</b> <b>AM</b> <b>PM</b>

Parent/guardian consent	
I give consent for this referral to GLCH paediatric team.	
I give consent to share relevant information with the professionals/services involved in clients care needs.	
Name	Date
Parent/guardian signature	
Verbal consent (for phone referrals) <b>Yes</b> <b>No</b>	

Please return the completed referral form to our Service Access team via email to [serviceaccess@glch.org.au](mailto:serviceaccess@glch.org.au) or phone 5155 8367 for assistance.