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, please contact our intake team on 51558367 to complete the referral form.

Details of Person completing referral:
Name of referrer:
Position/Profession/ Relationship to child:
Service (if relevant):
Other referrals completed: (eg Paediatrician, NDIS, early help, IFS, orange door):
Would this family benefit from a keyworker referral: Yes ☐ No ☐ Unsure ☐
Please inform the referrer if unable to contact: Yes ☐ No ☐

Child Details	
Child's First Name:	**Child's Surname:**
Preferred Name:	**Pronouns:**
Gender:	**Date of Birth:**
Address:	
Country of Birth: **Language Spoken at home:**	**Interpreter Required: Yes ☐ No ☐** **Language:**
Parent/Carer Contact details:	
Carer 1 Full name:	**Carer 2 Full name:**
Relationship to Child:	**Relationship to child:**
Phone:	**Phone:**
Email:	**Email:**
Interpreter Required: Yes ☐ No ☐ **Language:**	**Interpreter Required: Yes ☐ No ☐** **Language:**
Are there any family court orders regarding this child (if so please provide details):	
Living arrangements if living between carers:	

REFERRAL DETAILS
Referral for: ☐ Occupational Therapy ☐ Speech Pathology ☐ Physiotherapy ☐ Feeding clinic ☐ ADOS clinic (requires paediatrician referral)

Reason for Referral: (please 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
Born at: …… **weeks** **Birth weight:** **Estimated due date:** **Delivery type**: (vaginal, planned caesarean, unplanned caesarean): **Location of delivery**: (home birth, hospital name):
Was your child exposed to medications or alcohol during pregnancy? Medication expose ☐ Alcohol exposure ☐ Unsure of alcohol or medicine exposure ☐ Child was not exposed to alcohol or medications during pregnancy ☐
Were there any complications during or just after the birth (e.g. Special Care Nursery, oxygen, tube feeding, APGAR score, referrals post hospital discharge). Please provide details:

Medical History		
Formal Diagnosis/relevant medical information: **Allergies:**		
My child has had a hearing check	**Date:**	**Outcome:**
My child has had a vision assessment:	**Date:**	**Outcome:**
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		
General practitioner:	Name:	Clinic:
Paediatrician:	Name:	Clinic:
Education (school, childcare, kinder):	Name:	Year level/Days attended:
Other Services: (MCHN, ENT, Allied health professionals, NDIS, tertiary hospitals, Early Help, Orange Door, IFS)	Service Name: Service Name: Service Name: Service Name: Service Name:	Contact: Contact: Contact: Contact: Contact:

Child is starting school in the next 12 months	**Yes** ☐ **No** ☐	**Name of School:**
Child is in Out of Home Care	**Yes** ☐ **No** ☐	
Aboriginal or Torres strait Islander	**Yes** ☐ **No** ☐	

Other relevant information
Is there any history of family violence? **Yes** ☐ **No** ◉ Are there any family relationship issues that may be affecting your child? **Yes** ☐ **No** ◉ Any stressors or barriers to attendance (eg. Method of contact, transport, financial, work)? **Yes** ☐ **No** ◉ Details:
Availabilities for appointments (tick boxes) **Monday** ☐ **Tuesday** ☐ **Wednesday** ☐ **Thursday** ☐ **Friday** ☐ **AM** ☐ **PM** ☐

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: Parent/Guardian Verbal consent (for phone referrals): **Yes** ☐ **No** ☐	Date:

Please return the completed form to our service access team to process the referral.
serviceaccess@glch.org.au or 51558367