Eastern Health

PAEDIATRIC REFERRAL FORM COMMUNITY HEALTH SERVICES

UR number:

Surname:

Given name:

Date of birth: DD/MM/YYYY Sex:

(Affix hospital ID label if available)

Please support families to access the correct service by completing all fields

Eastern Health Community Health
Phone: 1300 130 381 (Option 4)
communityhealth@easternhealth.org.au

Community health eligibility:

Community health is a government funded program to assist people on lower incomes access health services.

To access community health services, children must:
(Must tick all boxes)

- ☐ Not be eligible for NDIS or other funded service
- ☐ Be within age range of services as listed below
- ☐ Annual family income < $118,546 with one child, plus $6,206 per additional child (Exception: ATSI background)

Please indicate below if the child / family you are referring experiences additional vulnerabilities that are a barrier to them accessing other services (E.g. ATSI, F / V, refugee, service delivery gaps):

Needs / vulnerabilities identified:

Admin only: ☐ For discussion with team leader

To which service(s) are you referring?

Paediatric Occupational Therapy (6 months to end of prep):	☐ Maroondah	☐ Healesville	☐ Yarra Junction
Child Counselling (< 12 years of age):	☐ Healesville only		
Paediatric Dietitian (< 12 years of age):	☐ Maroondah	☐ Healesville	☐ Yarra Junction
Speech Pathology (infants and pre school):	☐ Maroondah	☐ Healesville	☐ Yarra Junction
Feeding Clinic (< 6 years of age):	☐ Maroondah	☐ Healesville	

Locations:

- Maroondah: 24 Grey Street, Ringwood East 3135
- Healesville Hospital and Yarra Valley Health: 377 Maroondah Hwy, Healesville 3777
- Upper Yarra Family Centre: 2444 Warburton Hwy, Yarra Junction 3797

Note: it may take up to 10 working days to acknowledge your referral.
If this child requires urgent care please refer them to a Medical Practitioner.

FEH090650

Allanby Press EH090650 18/01/23

PAEDIATRIC REFERRAL FORM COMMUNITY HEALTH SERVICES EH 090650

Eastern Health

PAEDIATRIC REFERRAL FORM
COMMUNITY HEALTH SERVICES

UR number:

Surname:

Given name:

Date of birth: DD/MM/YYYY Sex:

(Affix hospital ID label if available)

Client history

Reason for referral and referrer comments (Please provide as much detail as possible):

Medical history (E.g. prematurity, allergies, chronic health issues): Attached

Relevant family history (Recent separation, bereavement, moved house, family violence etc.):

Please indicate whether you feel the child's difficulties are: ☐ Mild ☐ Moderate ☐ Severe

Has the child had a hearing test by an audiologist? ☐ No ☐ Yes Results:

Has the child had his / her vision assessed? ☐ No ☐ Yes Results:

Any other relevant tests? ☐ No ☐ Yes (Please attach)

Is the child currently receiving services elsewhere? ☐ No ☐ Yes (If yes, please provide details)

Please indicate family members, names and ages of siblings:

Are the parents / carers finding it difficult to parent this child? ☐ No ☐ Yes (If yes, please provide details)

Are there any concerns about the safety of the child or family? (Including family violence)
☐ No ☐ Yes (If yes, please provide details)

Are there any court orders relating to this child? ☐ No ☐ Yes (If yes, please attach)

Eastern Health

PAEDIATRIC REFERRAL FORM
COMMUNITY HEALTH SERVICES

UR number:

Surname:

Given name:

Date of birth: DD/MM/YYYY Sex:

(Affix hospital ID label if available)

FEH090650

Client details

Child's name:	
Date of birth: DD/MM/YYYY	Gender: ☐ Female ☐ Male ☐ Other
Address:	
Suburb:	Post code:
Parent / guardian names:	
Phone:	Email:
Interpreter required? ☐ No ☐ Yes	If yes, preferred language?

Referrer details

Referrer name:				
Organisation:				
Contact details:	Phone:		Fax:	
Please provide at least one form of contact.	Email:			
Postal address:				
Client consent obtained for referral? ☐ Yes ***(Required)***		Date of referral:	DD/MM/YYYY	
How would you prefer to hear about the outcome of this referral? (E.g. phone, email, post?)				

Office use only

	Date:		
Referral received:	DD/MM/YYYY	Rejected?	☐ Yes
Referrer acknowledged:	DD/MM/YYYY	Reason:	
Initial contact:	DD/MM/YYYY		

PAEDIATRIC REFERRAL FORM COMMUNITY HEALTH SERVICES EH 090650

Allanby Press EH090650 11/01/23

Eastern Health

PAEDIATRIC REFERRAL FORM
COMMUNITY HEALTH SERVICES

UR number:

Surname:

Given name:

Date of birth: DD/MM/YYYY Sex:

(Affix hospital ID label if available)

Concerns / reasons for referral: Please include an ISOBAR Handover Form

Please indicate if there are concerns in each of the main headings. **If yes, tick all relevant items in each box:** We use this information to make sure that we provide the right services for each family. Please provide as much information as possible.

Gross motor **OT**

☐ No ☐ Yes

☐ Infant neurodevelopmental assessment

Concerns regarding development of:

Crawling
☐ Walking / running
☐ Jumping / hopping

☐ Other

Fine motor **OT**

☐ No ☐ Yes

Child has difficulty:
☐ Picking up and using objects
☐ Using 2 hands together
☐ Cutting with scissors

Cognitive **OT**

☐ No ☐ Yes

☐ Unable to put together puzzles
☐ Limited or no Pretend / imaginary play
☐ Repetitive play
☐ Playing with other children is difficult
☐ Learning new skills takes a lot of time

Self care **OT**

☐ No ☐ Yes

Child has difficulty:
☐ Dressing
☐ Toileting
☐ Eating with fork / spoon
☐ Washing / drying hands

Pre – writing **OT**

☐ No ☐ Yes

☐ Swapping hands when drawing

Child has difficulty:
☐ Holding a pencil correctly
☐ Drawing
☐ Colouring within lines (4 - 5 years)
☐ Copying shapes

Attention **OT**

☐ No ☐ Yes

Child has difficulty:
☐ Focussing on tasks
☐ Attention and concentration
☐ Sitting still / group time
☐ Attending to instructions
☐ Being too active for the situation
☐ Following routines

Diet / nutrition **DT**

☐ No ☐ Yes

☐ Fussy eating
☐ Allergy or intolerance
☐ Overweight
☐ Underweight
☐ Constipation
☐ Other

Sensory / behaviour **OT**

☐ No ☐ Yes

☐ Has difficulty with transitions
☐ Easily upset over accidents
☐ Difficulty with change in routine
☐ Upset over loud noises
☐ Upset about food textures
☐ Upset about clothing textures
☐ Big meltdowns

Feeding **SP / OT / DT**

☐ No ☐ Yes

☐ Bottle feeding concerns
☐ Breast feeding concerns
☐ Transition to solid foods
☐ Gagging
☐ Choking
☐ Chewing concerns
☐ Drinking from a cup
☐ Mealtime stress e.g. caregiver anxiety, child distress
☐ Difficult mealtime behaviour
☐ Other

Speech sounds **SP**

☐ No ☐ Yes

☐ Difficulty with a few sounds.
☐ Difficulty with many sounds
☐ Sometimes becomes distressed if they are not understood
☐ Family has difficulty understanding the child
☐ Others have difficulty understanding the child
☐ Child over 2½ yrs is still dribbling

Understanding language **SP**

☐ No ☐ Yes

Child has difficulty:
☐ Following instructions.
☐ Learning basic concepts (Names, objects, colours, etc.)
☐ Understanding conversations.
☐ Needs directions / information to be consistently repeated
☐ Listening and maintaining attention.
☐ For bilingual children:
☐ The child has difficulty understanding/using their home / main language.

Using language **SP**

☐ No ☐ Yes

For the younger child:
☐ Not using gestures / pointing
☐ Not using many single words
☐ No 2 word combinations
☐ Not using sentences of 3 words or more

For the older child:
☐ Difficulty putting words together into sentences.
☐ Difficulty describing or retelling an event at age 4 yrs or older.

Stuttering **SP**

☐ No ☐ Yes

☐ Stuttering for less than 6 months
☐ Stuttering for more than 6 months.
☐ Blocks or get stuck on a word so that no sound comes out.
☐ Stretches sounds e.g. mmmmum
☐ Repeats sounds, words, or phrases
☐ Shows signs of physical tension when stuttering e.g. head jerking, eye blinking
☐ Child is frustrated by the stuttering

Social skills **SP / OT / SW**

☐ No ☐ Yes

Child has difficulty:
☐ Responding to their name
☐ Maintaining eye contact
☐ Staying on topic
☐ Playing with other children
☐ Sharing with others or taking turns
☐ Showing / sharing experiences with parents / carers
☐ Paying attention to conversation

Other: