PAEDIATRIC REFERRAL FORM
Community Health Services

Write legibly in black or blue pen.

Eastern Health
Community Health Services

First Name ……………………………………….

Surname ………………………………………….

Female ☐ **Male** ☐ **Other** ☐

PLEASE SUPPORT FAMILIES TO ACCESS THE CORRECT SERVICE BY COMPLETING ALL FIELDS

Eastern Health Community Health
Phone: 1300 130 381 (option 4) Fax: 5962 1458
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 (eg. 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 *(6months to end of grade 1)*: ☐ Maroondah ☐ Healesville ☐ Yarra Junction

Paediatric Physiotherapy *(<12 years of age)*: ☐ Maroondah only

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.

Community Health Paediatric Referral Form EH090650

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Eastern Health
Community Health Services

First Name ....

Surname ....

Female ☐ Male ☐ Other ☐

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)

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Surname …………………………………………..

Female ☐ Male ☐ Other ☐

Client Details

Child's Name:	
Date of Birth:	Gender: Female ☐ Male ☐ Other ☐
Address:	
Suburb:	Post Code:
Parent / Guardian names:	
Phone:	Email:
Interpreter Required? ☐ Yes ☐ No	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:	
How would you prefer to hear about the outcome of this referral? (eg. phone, email, post?)				

OFFICE USE ONLY			
	Date:		
Referral Received:		*Rejected?*	☐ *Yes*
Referrer Acknowledged:		*Reason:*	
Initial Contact:			

Community Health Paediatric Referral Form EH090650

Eastern Health

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Eastern Health
Community Health Services

First Name ……………………………………….

Surname ………………………………………….

Female ☐ **Male** ☐ **Other** ☐

CONCERNS / Reasons for referral:
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/PT
☐ YES ☐ NO

- ❑ Infant neurodevelopmental assessment

Concerns regarding development of:
- ❑ Head/Neck control
- ❑ Sitting/Crawling
- ❑ Walking/Running
- ❑ Jumping/Hopping
- ❑ Postural variations – Bow legs/Knock knees/Flat foot
- ❑ Limping/Intoeing/Toe walking
- ❑ Other ……………….

Fine Motor — OT
☐ YES ☐ NO

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

Cognitive — OT
☐ YES ☐ NO

- ❑ 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
☐ YES ☐ NO

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

Pre – Writing — OT
☐ YES ☐ NO

- ❑ Swapping hands when drawing

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

Attention — OT
☐ YES ☐ NO

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

Diet / Nutrition — DT
☐ YES ☐ NO

- ❑ Fussy eating
- ❑ Allergy or intolerance
- ❑ Overweight
- ❑ Underweight
- ❑ Constipation
- ❑ Other ………….

Sensory/Behaviour — OT
☐ YES ☐ NO

- ❑ 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
☐ YES ☐ NO

- ❑ Bottle feeding concerns
- ❑ Breastfeeding 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
☐ YES ☐ NO

- ❑ 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 2½yrs is still dribbling

Understanding Language — SP
☐ YES ☐ NO

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
☐ YES ☐ NO

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
☐ YES ☐ NO

- ❑ 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 eg mmmmum
- ❑ Repeats sounds, words, or phrases
- ❑ Shows signs of physical tension when stuttering eg. head jerking, eye blinking
- ❑ Child is frustrated by the stuttering

Social Skills — SP/OT/SW
☐ YES ☐ NO

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: