FEH090650

easternhealth
GREAT HEALTH AND WELLBEING

PAEDIATRIC REFERRAL FORM
Community Health Services

Write legibly in black or blue pen.

Eastern Health
Community Health Services

PLEASE DIRECT YOUR REFERRAL TO THE APPROPRIATE SERVICE

PLEASE HELP US SUPPORT FAMILIES WITH THE RIGHT SERVICE BY COMPLETING ALL FIELDS

Healesville Hospital and Yarra Valley Health
377 Maroondah Hwy, Healesville 3777
2475 Warburton Hwy, Yarra Junction 3797
Phone: 1300 130 381 Fax: 5962 1458
communityhealth@easternhealth.org.au

- ☐Paediatric Occupational Therapy *(0-8)*
- ☐Paediatric Physiotherapy *(0-12)*
- ☐Paediatric Speech Pathology *(preschool)*
- ☐Paediatric Dietitian *(0-17)*
- ☐Early Skills Check *(1-5)*
- ☐Child and Family Counsellor *(0-12)*
- ☐Supported Playgroup *(preschool)*
- ☐Healthy Mother Healthy Babies *(pregnant women)*

Maroondah Community Health
24 Grey Street,
Ringwood East
Phone: 9871 3599 Fax 9955 1121 *(we prefer email please)*
maroondahcommunityhealth@easternhealth.org.au

- ☐ Paediatric Speech Pathology *(preschool)*
- ☐ Paediatric Occupational Therapy *(0-8)*
- ☐ Paediatric Physiotherapy *(0-12)*
- ☐ Paediatric Dietitian *(0-18)*

Client History

Reason for referral and referrer comments:

See Page 3 for further detail

Medical History: ☐ *attached*

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

Is the child currently receiving services anywhere? (details)

Is the child on a waiting list anywhere? (details)

Please indicate family members, names and ages of siblings:

Have there been any stresses, trauma or changes in the family in the last few years (eg, separation, moving house, death of a relative, unemployment, depression etc)?

Are the parents finding it difficult to parent this child?

Are there any concerns about the safety of the child or family?

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Client Details

Child's Name:			
Date of Birth:		Country of Birth:	
Address:			
Suburb:		Post Code:	
Parent / Guardian names:			
Phone:		Email:	
Identify as Aboriginal / T.S Islander?	☐ Yes ☐ No	Refugee Status:	☐ Yes ☐ No
Interpreter Required?	☐ Yes ☐ No	If yes, preferred language?	
Medicare Card Number:	_ _ _ _ _ _ _ _ _ _ / _	Private Health insurance?	☐ Yes ☐ No
☐ Health Care Card ☐ Pension Card ☐ NDIS eligible		Reference No.	

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 (This is Required)		Date of Referral:	

How would you prefer to hear about the outcome of this referral?
(Eg. phone, email, written report?)

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

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Does the child have difficulty with:

Please indicate if there are concerns in each of the main headings. **If yes, tick all relevant items in each box**:

Gross Motor **OT/PT**
☐ YES ☐ NO

- ❑ Ball Skills
- ❑ Balance
- ❑ Jumping or hopping
- ❑ Confidence on outdoor equipment
- ❑ Running
- ❑ Walking
- ❑ Other ……

Fine Motor **OT**
☐ YES ☐ NO

- ❑ Picking up and using objects
- ❑ Using 2 hands together
- ❑ Cutting with scissors

Cognitive **OT**
☐ YES ☐ NO

- ❑ Puzzles
- ❑ Pretend/imaginary play
- ❑ Copying
- ❑ Playing with other children
- ❑ Learning

Self Care **OT**
☐ YES ☐ NO

- ❑ Dressing
- ❑ Toileting
- ❑ Eating with fork/spoon
- ❑ Washing/drying hands

Pre – Writing **OT**
☐ YES ☐ NO

- ❑ Swapping hands when drawing
- ❑ Holding a pencil correctly
- ❑ Drawing
- ❑ Colouring within lines (4-5 years)
- ❑ Copying shapes

Attention **OT**
☐ YES ☐ NO

- ❑ Focussing on tasks
- ❑ Attention & concentration
- ❑ Sitting still/group time
- ❑ Following instructions
- ❑ Very active
- ❑ Following routines

Diet / Nutrition **DT**
☐ YES ☐ NO

- ❑ Fussy eating
- ❑ Allergy or intolerance
- ❑ Overweight
- ❑ Underweight
- ❑ Constipation
- ❑ Transition to solid foods
- ❑ Other ……

Sensory **OT**
☐ YES ☐ NO

- ❑ Dislikes height/moving equipment
- ❑ Easily upset over accidents
- ❑ Doesn't like getting hands messy/hair or teeth brushed
- ❑ Upset over loud noises or clothes textures

Early Skills Check may be suitable for children for whom concerns are indicated across more than one discipline.
SP Speech Pathologist
OT – Occupational Therapist
DT – Dietitian
PT – Physiotherapist
CC – Children's Counsellor

Speech Sounds **SP**
☐ YES ☐ NO

- ❑ Difficulty with a few sounds.
- ❑ Difficulty with many sounds
- ❑ Sometimes becomes distressed if they not understood
- ❑ Family has difficulty understanding the child
- ❑ Others have difficulty understanding the child
- ❑ Dribbling is an concern beyond 2 ½ yrs.

Understanding Language **SP**
☐ YES ☐ NO

- ❑ Following simple 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:

- ❑ Gestures/pointing
- ❑ Single words
- ❑ 2 word combinations
- ❑ Sentences of 3 words or more

For the older child:

- ❑ Putting words together into sentences.
- ❑ Describing or retelling an event at age 4 yrs or older.
- ❑ Having a conversation eg. attending to conversation, staying on topic

Stuttering (3yrs+) **SP**
☐ YES ☐ NO

- ❑ Stuttering on & off for more than 6 mths.
- ❑ Blocks or get stuck on a word so that no sound comes out.
- ❑ Stretches sounds eg mmmmum
- ❑ Repeats sounds, words, or phrases is frustrated by the stuttering.
- ❑ Shows signs of physical tension when stuttering eg. head jerking, hand/toe tapping

Voice **SP**
☐ YES ☐ NO

- ❑ Persistently hoarse / husky voice.
- ❑ Often has periods of no voice
- ❑ Has a nasal voice

Social/ Emotional Skills **CC**
☐ YES ☐ NO

- ❑ Playing with other children (tends to play alone at 3 yrs or older)
- ❑ Maintaining eye contact.
- ❑ New people, experiences or changes.
- ❑ Being co-operative with parents
- ❑ Being co-operative with other carers
- ❑ Being affectionate
- ❑ Managing their emotions (eg tantrums)
- ❑ Aggression
- ❑ Shyness
- ❑ Understanding others' emotions