





**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)

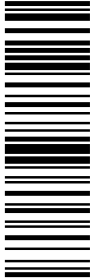
Are there any court orders relating to this child?  No  Yes (If yes, please attach)

\_\_\_\_\_  
\_\_\_\_\_



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FEH090650

**Client details**

Child's name: \_\_\_\_\_ Date of birth: **DD/MM/YYYY**

Gender: Male Female Non-binary Not Stated They use a different term: \_\_\_\_\_

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: _____
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Please provide at least one form of contact.	Email: _____
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Postal address: _____
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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:	<b>DD/MM/YYYY</b>	Rejected?	<input type="checkbox"/> Yes
Referrer acknowledged:	<b>DD/MM/YYYY</b>	Reason: _____	
Initial contact:	<b>DD/MM/YYYY</b>		

Allanby Press EH090650 11/01/23

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EH 090650

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**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.

<b>Gross motor (3yrs Plus) OT</b> <input type="checkbox"/> No <input type="checkbox"/> Yes	<b>Fine motor OT</b> <input type="checkbox"/> No <input type="checkbox"/> Yes	<b>Cognitive OT</b> <input type="checkbox"/> No <input type="checkbox"/> Yes
Crawling <input type="checkbox"/> Walking / running <input type="checkbox"/> Jumping / hopping  <input type="checkbox"/> Other _____	Child has difficulty: <input type="checkbox"/> Picking up and using objects <input type="checkbox"/> Using 2 hands together <input type="checkbox"/> Cutting with scissors	<input type="checkbox"/> Unable to put together puzzles <input type="checkbox"/> Limited or no Pretend / imaginary play <input type="checkbox"/> Repetitive play <input type="checkbox"/> Playing with other children is difficult <input type="checkbox"/> Learning new skills takes a lot of time
<b>Self care OT</b> <input type="checkbox"/> No <input type="checkbox"/> Yes  Child has difficulty: <input type="checkbox"/> Dressing <input type="checkbox"/> Toileting <input type="checkbox"/> Eating with fork / spoon <input type="checkbox"/> Washing / drying hands	<b>Pre – writing OT</b> <input type="checkbox"/> No <input type="checkbox"/> Yes  <input type="checkbox"/> Swapping hands when drawing Child has difficulty: <input type="checkbox"/> Holding a pencil correctly <input type="checkbox"/> Drawing <input type="checkbox"/> Colouring within lines (4 - 5 years) <input type="checkbox"/> Copying shapes	<b>Attention OT</b> <input type="checkbox"/> No <input type="checkbox"/> Yes  Child has difficulty: <input type="checkbox"/> Focussing on tasks <input type="checkbox"/> Attention and concentration <input type="checkbox"/> Sitting still / group time <input type="checkbox"/> Attending to instructions <input type="checkbox"/> Being too active for the situation <input type="checkbox"/> Following routines
<b>Diet / nutrition DT</b> <input type="checkbox"/> No <input type="checkbox"/> Yes  <input type="checkbox"/> Fussy eating <input type="checkbox"/> Allergy IgE (please refer to Allergy DT) Intolerance / Non IgE Allergy <input type="checkbox"/> Overweight <input type="checkbox"/> Underweight <input type="checkbox"/> Constipation <input type="checkbox"/> Other _____	<b>Sensory / behaviour OT</b> <input type="checkbox"/> No <input type="checkbox"/> Yes  <input type="checkbox"/> Has difficulty with transitions <input type="checkbox"/> Easily upset over accidents <input type="checkbox"/> Difficulty with change in routine <input type="checkbox"/> Upset over loud noises <input type="checkbox"/> Upset about food textures <input type="checkbox"/> Upset about clothing textures <input type="checkbox"/> Big meltdowns	<b>Feeding SP / OT / DT</b> <input type="checkbox"/> No <input type="checkbox"/> Yes  <input type="checkbox"/> Bottle feeding concerns <input type="checkbox"/> Breast feeding concerns <input type="checkbox"/> Transition to solid foods <input type="checkbox"/> Gagging <input type="checkbox"/> Choking <input type="checkbox"/> Chewing concerns <input type="checkbox"/> Drinking from a cup <input type="checkbox"/> Mealtime stress e.g. caregiver anxiety, child distress <input type="checkbox"/> Difficult mealtime behaviour <input type="checkbox"/> Other _____
<b>Speech sounds SP</b> <input type="checkbox"/> No <input type="checkbox"/> Yes  <input type="checkbox"/> Difficulty with a few sounds. <input type="checkbox"/> Difficulty with many sounds <input type="checkbox"/> Sometimes becomes distressed if they are not understood <input type="checkbox"/> Family has difficulty understanding the child <input type="checkbox"/> Others have difficulty understanding the child <input type="checkbox"/> Child over 2½ yrs is still dribbling	<b>Understanding language SP</b> <input type="checkbox"/> No <input type="checkbox"/> Yes  Child has difficulty: <input type="checkbox"/> Following instructions. <input type="checkbox"/> Learning basic concepts (Names, objects, colours, etc.) <input type="checkbox"/> Understanding conversations. <input type="checkbox"/> Needs directions / information to be consistently repeated <input type="checkbox"/> Listening and maintaining attention. <input type="checkbox"/> For bilingual children: <input type="checkbox"/> The child has difficulty understanding/using their home / main language.	<b>Using language SP</b> <input type="checkbox"/> No <input type="checkbox"/> Yes  For the younger child: <input type="checkbox"/> Not using gestures / pointing <input type="checkbox"/> Not using many single words <input type="checkbox"/> No 2 word combinations <input type="checkbox"/> Not using sentences of 3 words or more For the older child: <input type="checkbox"/> Difficulty putting words together into sentences. <input type="checkbox"/> Difficulty describing or retelling an event at age 4 yrs or older.
<b>Stuttering SP</b> <input type="checkbox"/> No <input type="checkbox"/> Yes  <input type="checkbox"/> Stuttering for less than 6 months <input type="checkbox"/> Stuttering for more than 6 months. <input type="checkbox"/> Blocks or get stuck on a word so that no sound comes out. <input type="checkbox"/> Stretches sounds e.g. mmmmm <input type="checkbox"/> Repeats sounds, words, or phrases <input type="checkbox"/> Shows signs of physical tension when stuttering e.g. head jerking, eye blinking <input type="checkbox"/> Child is frustrated by the stuttering	<b>Social skills SP / OT / SW</b> <input type="checkbox"/> No <input type="checkbox"/> Yes  Child has difficulty: <input type="checkbox"/> Responding to their name <input type="checkbox"/> Maintaining eye contact <input type="checkbox"/> Staying on topic <input type="checkbox"/> Playing with other children <input type="checkbox"/> Sharing with others or taking turns <input type="checkbox"/> Showing / sharing experiences with parents / carers <input type="checkbox"/> Paying attention to conversation	<b>Other:</b>