



PAEDIATRIC REFERRAL FORM

CHILD YOUTH & FAMILY HEALTH SERVICES

Kirwan Health Campus
PO Box 1596, Thuringowa Central 4817
Ph: (07) 4799 9000 Fax: (07) 4799 9001

URN: _____

Family Name: _____

Given Names: _____

Address: _____

Date of Birth: _____

Sex: M F

Person Completing Referral Form: _____

Date of Referral: _____

CHILD DETAILS:

Surname: _____ Given Names: _____

Date of Birth: _____ Sex: _____ TDHS UR #: _____ Child Health Chart: Yes / No / ?

Address: _____ Suburb: _____ Post Code: _____

School: _____ Teacher: _____ Grade/Class: _____

Does Child Identify as: Aboriginal: Yes / No Torres Strait Islander: Yes / No South Sea Islander: Yes / No

Medical Conditions / Disabilities: _____

Current GP/ Specialist (eg Paediatrician) including TTH: _____

FAMILY DETAILS:

PLEASE PROVIDE SURNAME OF BOTH PARENTS

Mother's

FULL Name: _____ Address: _____

Phone No: _____ Mobile Phone No: _____ Daytime Contact Phone No: _____

Father's

FULL Name: _____ Address: _____

Phone No: _____ Mobile Phone No: _____ Daytime Contact Phone No: _____

Siblings: _____

Parents Aware of Referral (*parents must support referral*): Mother: Yes No Father: Yes No

REFERRAL SOURCE:

Name: _____ Profession: _____

Agency: _____ Address: _____

Phone No: _____ Suburb: _____ Post Code: _____

SERVICES REQUESTED:

Medical/Specialist Occupational Therapy Physiotherapy Social Worker Speech Pathology

TDHS Paediatric Intake Meeting Use Only

Intake Meeting Date: ____ / ____ / ____

Referral Assigned To:

Agency:

Advice letter posted to parent/guardian

Advice letter posted to referring agent

Referral Not Accepted Action: _____

DO NOT WRITE IN THIS BINDING MARGIN



PAEDIATRIC REFERRAL FORM

CHILD YOUTH & FAMILY HEALTH SERVICES

Townsville Health Service District

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth:

Sex: M F

REASON FOR REFERRAL -

Please tell us why you are referring this child to us by identifying your concerns in any of the following areas.

Gross Motor Skills / Mobility (eg crawling, walking, running, jumping, balance/co-ordination) _____

Fine Motor Skills (handwriting, cutting, fine manipulative skills) _____

Speech and Language _____

Eating & Drinking Skills _____

Reading Skills _____

Behaviour _____

Concentration / Distractibility _____

Other Concerns _____

OTHER SERVICES INVOLVED (eg. Specialist Medical, Hearing, Optometric, Ed Qld Therapy Services)

ANY OTHER RELEVANT INFORMATION:

Please Note: Parents / referring agents may be contacted for further information.



DO NOT WRITE IN THIS BINDING MARGIN

