

REFERRAL FORM

Date of Referral: _____

CHILD'S DETAILS:

Surname: _____ Given Names: _____

Date of Birth: _____ Sex: _____ TDHS UR #: _____ *Child Health Chart: yes / no / ?*

Address: _____ Suburb: _____ Post Code: _____

School: _____ Teacher: _____ Grade/Class: _____

Medical Conditions / Disabilities: _____

Current GP/ Specialist (eg Paediatrician): _____

FAMILY DETAILS:

Mother's Name: _____ Phone No: _____

Address: _____

Father's Name: _____ Phone No: _____

Address: _____

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: Med / OT / PT / SW / SP *Agency:* CCTS / CHS / CH / TTH

Advice letter posted to parent/guardian *Advice letter posted to referring agent*

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:

