FEH090650

easternhealth
GREAT HEALTH AND WELLBEING

# 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 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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**Female ☐ Male ☐ Other ☐**

## 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<br>☐ Pension Card<br>☐ 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:* | | | |

**Community Health Paediatric Referral Form EH090650**

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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 | Fine Motor **OT** ☐ YES ☐ NO | Cognitive **OT** ☐ YES ☐ NO |
|---|---|---|
| ❑ Ball Skills<br>❑ Balance<br>❑ Jumping or hopping<br>❑ Confidence on outdoor equipment<br>❑ Running<br>❑ Walking<br>❑ Other …… | ❑ Picking up and using objects<br>❑ Using 2 hands together<br>❑ Cutting with scissors | ❑ Puzzles<br>❑ Pretend/imaginary play<br>❑ Copying<br>❑ Playing with other children<br>❑ Learning |
| **Self Care OT** ☐ YES ☐ NO | **Pre – Writing OT** ☐ YES ☐ NO | **Attention OT** ☐ YES ☐ NO |
| ❑ Dressing<br>❑ Toileting<br>❑ Eating with fork/spoon<br>❑ Washing/drying hands | ❑ Swapping hands when drawing<br>❑ Holding a pencil correctly<br>❑ Drawing<br>❑ Colouring within lines (4-5 years)<br>❑ Copying shapes | ❑ Focussing on tasks<br>❑ Attention & concentration<br>❑ Sitting still/group time<br>❑ Following instructions<br>❑ Very active<br>❑ Following routines |
| **Diet / Nutrition DT** ☐ YES ☐ NO | **Sensory OT** ☐ YES ☐ NO | |
| ❑ Fussy eating<br>❑ Allergy or intolerance<br>❑ Overweight<br>❑ Underweight<br>❑ Constipation<br>❑ Transition to solid foods<br>❑ Other …… | ❑ Dislikes height/moving equipment<br>❑ Easily upset over accidents<br>❑ Doesn't like getting hands messy/hair or teeth brushed<br>❑ 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.*<br>*SP Speech Pathologist*<br>*OT – Occupational Therapist*<br>*DT – Dietitian*<br>*PT – Physiotherapist*<br>*CC – Children's Counsellor* |
| **Speech Sounds SP** ☐ YES ☐ NO | **Understanding Language SP** ☐ YES ☐ NO | **Using language SP** ☐ YES ☐ NO |
| ❑ Difficulty with a few sounds.<br>❑ Difficulty with many sounds<br>❑ Sometimes becomes distressed if they not understood<br>❑ Family has difficulty understanding the child<br>❑ Others have difficulty understanding the child<br>❑ Dribbling is an concern beyond 2 ½ yrs. | ❑ Following simple instructions.<br>❑ Learning basic concepts (names, objects, colours, etc.)<br>❑ Understanding conversations.<br>❑ Needs directions/information to be consistently repeated<br>❑ Listening and maintaining attention.<br>For bilingual children:<br>❑ The child has difficulty understanding/using their home/main language. | For the younger child:<br>❑ Gestures/pointing<br>❑ Single words<br>❑ 2 word combinations<br>❑ Sentences of 3 words or more<br>For the older child:<br>❑ Putting words together into sentences.<br>❑ Describing or retelling an event at age 4 yrs or older.<br>❑ Having a conversation eg. attending to conversation, staying on topic |
| **Stuttering (3yrs+) SP** ☐ YES ☐ NO | **Voice SP** ☐ YES ☐ NO | **Social/ Emotional Skills CC** ☐ YES ☐ NO |
| ❑ Stuttering on & off for more than 6 mths.<br>❑ Blocks or get stuck on a word so that no sound comes out.<br>❑ Stretches sounds eg mmmmum<br>❑ Repeats sounds, words, or phrases is frustrated by the stuttering.<br>❑ Shows signs of physical tension when stuttering eg. head jerking, hand/toe tapping | ❑ Persistently hoarse / husky voice.<br>❑ Often has periods of no voice<br>❑ Has a nasal voice | ❑ Playing with other children (tends to play alone at 3 yrs or older)<br>❑ Maintaining eye contact.<br>❑ New people, experiences or changes.<br>❑ Being co-operative with parents<br>❑ Being co-operative with other carers<br>❑ Being affectionate<br>❑ Managing their emotions (eg tantrums)<br>❑ Aggression<br>❑ Shyness<br>❑ Understanding others' emotions |