The Royal Children's Hospital Melbourne
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The Royal Children's Hospital Melbourne

Centre for Community Child Health

Referral to Fellow in Community Child Health

UR Number:

CHILD'S SURNAME:

GIVEN NAME:

Address:

Phone: Mobile: Email:

Date of Birth: Age: Gender:

FAMILY DETAILS:

Mother/Carer's Name & Address:

Father/Carer's Name & Address:

Language usually spoken by family:

Interpreter required? No ☐ Yes ☐ (Language:)

Fellow will contact referring person to organise interpreter services. Please note: the referring organisation is responsible for interpreter costs

Aboriginal & Torres Strait Islander: Yes ☐ No ☐ Unknown ☐

Health Care Card: Yes ☐ No ☐ Unknown ☐

Does the child have DHHF CP involvement? No ☐ Yes ☐ If yes, name/ number for case manager:

Name and contact of GP (if known):

Has the child already seen a paediatrician? No ☐ Yes ☐ If yes, please provide details including paediatrician name/location seen:

Has PSFO/Allied health/Inclusion Professional/MCH been involved with the child? No ☐ Yes ☐

If yes, please attach report where possible.

CURRENTLY ATTENDING: (specify type of service eg. Childcare, preschool etc)

Agency: **Contact person:**

Address: **Email:**

Phone:

Also referred to: NDIS/ECEI? (Include referral date, reference number)

REFFERRED BY:

Name: **Agency:**

Discipline: **Phone:**

Address:

Email: **Date of referral:**

Reason for referral (please attach any reports or previous assessments):

PERMISSION FOR DOCTOR TO COMMUNICATE FINDINGS

I hereby give permission for the RCH Community Paediatric Fellow to communicate with the referrer.

Parent/Guardian Name:

Parent/Guardian signature: **Date:**

CONTACT DETAILS FOR COMMUNITY CLINIC (if known)

Clinic name (if known):

Paediatric fellow name (if known): **Email (if known):**

Please fax to (03) 9345 5034 or email screferrals@rch.org.au