HEAD TO HEALTH kids QUEENSLAND

For further information
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(Affix patient identification label here)

# Referral to Head To Health Kids Queensland - Brisbane

## CHILD DETAILS - referrals accepted for children prior to their 12th birthday

| | | |
|---|---|---|
| Last name | First name | URN |
| Preferred name | | |
| Date of birth & age | Gender (at birth) | Gender (current/if different) |
| Country of birth | Address | |
| School/Kindy or Daycare (if child enrolled) | | |
| Does your child identify as ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither ☐ South Sea Islander | | |
| If Medicare eligible - Card no | Reference | Expiry |

## PARENT/CARER/GUARDIAN DETAILS

| | |
|---|---|
| Last name | First name |
| Preferred name | Relationship to child |
| Country of birth | |
| Home address | |
| Contact details (email & mobile preferred) | |
| Language(s) spoken at home | Interpreter required? ☐ Yes ☐ No |

Are there any concerns relating to visiting the child at home (if necessary &/or appropriate)? ☐ Yes ☐ No
If **yes**, please describe

## REFERRER DETAILS

| | | |
|---|---|---|
| Does the parent/carer consent to this referral? ☐ Yes ☐ No | | |
| Name of person completing referral form | | |
| Role/designation | | |
| Organisation (if appropriate) | Provider number (if appropriate) | |
| Address | | |
| Phone | Signature | Date |
| Email | | |

## CURRENT CONCERNS

**What are the challenges the child is experiencing, and what would be the goals of intervention from our service?**

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Head to Health - Queensland is jointly funded by the Australian Government and the Queensland Government.

HEAD TO HEALTH QUEENSLAND

Australian Government

Queensland Government

## FUNCTION SCREENING QUESTIONS

**Are there concerns with any of the following (PLEASE TICK 'YES' OR 'NO' FOR ALL AREAS)**

| | |
|---|---|
| Engagement in or attending school / daycare / Kindy (attention, behaviour etc) | ☐ Yes ☐ No |
| Emotional wellbeing (managing own emotions appropriate for age, anxiety, withdrawal etc) | ☐ Yes ☐ No |
| Communication (speaking, understanding, expressing self etc) | ☐ Yes ☐ No |
| Social skills or play (playing with others, interest in playing, interaction with peers etc) | ☐ Yes ☐ No |
| Thinking / learning / problem solving skills | ☐ Yes ☐ No |
| Physical wellbeing (energy / activity levels / moving their body) | ☐ Yes ☐ No |

## SOCIAL DETERMINANT QUESTIONS

**Does the child &/or family identify with any of the following challenges?**

| | Child | Family |
|---|---|---|
| Refugee / asylum seeker status | ------ | ☐ Yes ☐ No |
| Housing instability | ------ | ☐ Yes ☐ No |
| Financial stress | ------ | ☐ Yes ☐ No |
| Domestic or family violence | ------ | ☐ Yes ☐ No |
| Involvement of Child Safety | ------ | ☐ Yes ☐ No |
| Disability or chronic illness | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Drug or alcohol misuse | ☐ Yes ☐ No | ☐ Yes ☐ No |
| History of incarceration (prison) | ☐ Yes ☐ No | ☐ Yes ☐ No |

**Are there any services involved in supporting this child/family? How has this been helpful?**

**Availability for sessions – please indicate if you have a preference of day to be seen**

| Monday | Tuesday | Wednesday | Thursday | Friday |
|---|---|---|---|---|
| ☐ AM ☐ PM | ☐ AM ☐ PM | ☐ AM ☐ PM | ☐ AM ☐ PM | ☐ AM ☐ PM |

**Please describe any relevant health history and medications for the child**