Queensland Government

Children's Health Queensland Hospital and Health Service

(Affix patient identification label here)

Child Health Service Referral

Has this referral been discussed with the child's Legal Guardian? ☐ Yes ☐ No

CHILD DETAILS

Family name	Given name	Date of birth	UR

Address:

Sex: ☐ Male ☐ Female ☐ Indeterminate

Country of birth:

Alerts / allergies:

☐ Aboriginal but not Torres Strait Islander origin
☐ Torres Strait Islander but not Aboriginal
☐ Both Aboriginal and Torres Strait Islander
☐ Not Aboriginal or Torres Strait Islander
☐ Not stated / unknown

FAMILY DETAILS

Legal Guardian: ☐ Parent/s ☐ Other:

Name: **Relationship:** **DOB:**

Phone: **Mobile:**

Address:

Language spoken at home: **Interpreter required?** ☐ Yes ☐ No

Other significant residential or non-residential Carer	Age / DOB	Relationship	Contact no:
Carer name:			
Sibling/s – Name:			
Name:			
Name:			

REFERRER DETAILS

Name: **Designation/role:**

Organisation:

Address:

Phone: **Date:** **Signature:**

Fax:

Email:

REFERRAL INFORMATION

Presenting concern and Parent or Legal Guardian's goals:

DO NOT WRITE IN THIS BINDING MARGIN

Family name	Date of birth	CHQ URN

Relevant medical history:

Relevant developmental history:

Parent/carer/family psychosocial history:

OTHER KEY CONTACTS

Other agencies / therapy services involved:

Supporting documentation attached? ☐ Yes ☐ No

SUBMIT

PRINT COMPLETED FORM AND FAX TO (07) 3068 3719 or scan and email to CHQ-CH-Referral@health.qld.gov.au

Enquiries: Central Access and Bookings Service 1300 245 126.

Service information: www.childrens.health.qld.gov.au/community-health/child-health-service

DO NOT WRITE IN THIS BINDING MARGIN