



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
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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:

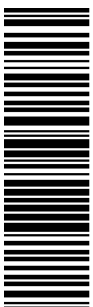
Fax:

Email:

REFERRAL INFORMATION

Presenting concern and Parent or Legal Guardian's goals:

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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

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

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