



Children's Health Queensland
Hospital and Health Service

**Ellen Barron Family Centre
Referral**

EBFC USE ONLY

Affix ieMR PARENT/CAREGIVER identification label here

DATE OF REFERRAL:

Service type: Inpatient Telehealth

REFERRING HEALTH PROFESSIONAL

| | | |
|----------------|---------|-------------|
| First name | Surname | Designation |
| Organisation | | |
| Postal Address | Suburb | Postcode |
| Phone | Fax | Email |

DETAILS OF PARENT / CARER

| | |
|--|--|
| Full name | Full name |
| Previous surname | Previous surname |
| Date of birth | Date of birth |
| Birth country | Birth country |
| Address | Address |
| Suburb | Postcode |
| Suburb | Postcode |
| Sex | Sex |
| Relationship status | Relationship status |
| Indigenous status | Indigenous status |
| Home phone | Mobile |
| Home phone | Mobile |
| Email | Email |
| Interpreter required? <input type="checkbox"/> Yes <input type="checkbox"/> No | Interpreter required? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Language | Language |

CHILD / CHILDREN WITH PRESENTING CONCERN

| | |
|---|---|
| Full Name | Full Name |
| Date of birth | Age |
| Date of birth | Age |
| Country of birth | Country of birth |
| Address | Address |
| Suburb | Postcode |
| Suburb | Postcode |
| Sex | Sex |
| Indigenous status | Indigenous status |
| Bed required? <input type="checkbox"/> Cot <input type="checkbox"/> Toddler Bed | Bed required? <input type="checkbox"/> Cot <input type="checkbox"/> Toddler Bed |

CHILD / CHILDREN REQUIRING ADMISSION AS BOARDER ONLY

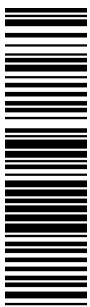
| | |
|---|---|
| Full Name | Full Name |
| Date of birth | Age |
| Date of birth | Age |
| Country of birth | Country of birth |
| Address | Address |
| Suburb | Postcode |
| Suburb | Postcode |
| Sex | Sex |
| Bed required? <input type="checkbox"/> Cot <input type="checkbox"/> Toddler Bed | Bed required? <input type="checkbox"/> Cot <input type="checkbox"/> Toddler Bed |

NEXT OF KIN DETAILS FOR PARENT / CAREGIVER

| | |
|---------|----------------------------------|
| Name | Date of birth |
| Address | Relationship to parent/caregiver |
| Name | Date of birth |
| Address | Relationship to parent/caregiver |

DO NOT WRITE IN THIS BINDING MARGIN

v7.00 - 08/2019



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Please add as much detail as possible when completing the sections below. Failure to provide adequate information will delay the admission progression. **NOTE: Co-sleeping is not supported at Ellen Barron Family Centre.**

REASON FOR REFERRAL (problem to be addressed, history of presenting concerns)

Sleep / settling (provide details of current settling)

Feeding issues - breastfeeding / bottle feeding / solids (provide details)

Behaviour (provide details)

Other (provide details)

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| CHILD 1 | | CHILD 2 | |
|---|----------------|---|----------------|
| Name | | Name | |
| Is the infant/child: <input type="checkbox"/> Breast fed <input type="checkbox"/> Bottle fed <input type="checkbox"/> On solids | | Is the infant/child: <input type="checkbox"/> Breast fed <input type="checkbox"/> Bottle fed <input type="checkbox"/> On solids | |
| Birth weight | Current weight | Birth weight | Current weight |
| Is there a concern with the child's weight? <input type="checkbox"/> Yes <input type="checkbox"/> No | | Is there a concern with the child's weight? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Relevant medical or developmental history | | Relevant medical or developmental history | |
| Current medication for child | | Current medication for child | |
| Current medication for parent | | | |
| Disability aids required? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |

PARENT / CARER INFORMATION

Parent's Mental Health
Have there been any episodes of diagnosed emotional/mental illness in the past 5 years where the parent/carer sought medical advice and/or counselling? Yes No

Please provide further information on mental health support that has been provided for the parent

Relevant issues regarding the caregiver e.g. substance abuse, trauma, social isolation, physical health/disability, learning/intellectual disability, domestic violence. If yes, provide details

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PARENT / CARER INFORMATION

Are there concerns regarding the parent-child relationship? If yes, provide details

Are there any current child protection concerns? If yes, provide details

Are Child Safety Services involved? Yes No

Child Safety Service Centre:

Contact person

Phone

Child Protection Order/Intervention

Family supports

Provide any additional relevant information that will be important for staff when reviewing this referral?

Have you discussed the referral and the information provided with the parent?

If not, why?

What other agents are currently providing services to the family?

- | | |
|--|---|
| <input type="checkbox"/> 0-4 CYMHS / CYMHS services | <input type="checkbox"/> Paediatrician service |
| <input type="checkbox"/> Adult Mental Health clinician | <input type="checkbox"/> Previous admission to Ellen Barron Family Centre |
| <input type="checkbox"/> Child Health Centre / day-stay / parent management clinic | <input type="checkbox"/> Previous admission to other residential/patient centre |
| <input type="checkbox"/> Department of Child Safety, Youth & Women | <input type="checkbox"/> Psychiatrist |
| <input type="checkbox"/> Intensive Family Support Service | <input type="checkbox"/> Other - specify: |
| <input type="checkbox"/> General Practitioner | |
| <input type="checkbox"/> Paediatric Allied Health - specify: | |

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Additional information:

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Please ensure all details are completed on all pages for prompt assessment of the referral.

| | | |
|-------------|------|-----------|
| Name | | Signature |
| Designation | Date | |