Queensland Government

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? ☐ Yes ☐ No	**Interpreter required?** ☐ Yes ☐ No
Language	**Language**

CHILD / CHILDREN WITH PRESENTING CONCERN

Full Name	**Full Name**
Date of birth **Age**	**Date of birth** **Age**
Country of birth Australia	**Country of birth** Australia
Address	**Address**
Suburb **Postcode**	**Suburb** **Postcode**
Sex	**Sex**
Indigenous status	**Indigenous status**
Bed required? ☐ Cot ☐ Toddler Bed	**Bed required?** ☐ Cot ☐ Toddler Bed

CHILD / CHILDREN REQUIRING ADMISSION AS BOARDER ONLY

Full Name	**Full Name**
Date of birth **Age**	**Date of birth** **Age**
Country of birth Australia	**Country of birth** Australia
Address	**Address**
Suburb **Postcode**	**Suburb** **Postcode**
Sex	**Sex**
Bed required? ☐ Cot ☐ Toddler Bed	**Bed required?** ☐ Cot ☐ 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**

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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: ☐ Breast fed ☐ Bottle fed ☐ On solids	**Is the infant/child:** ☐ Breast fed ☐ Bottle fed ☐ On solids
Birth weight **Current weight**	**Birth weight** **Current weight**
Is there a concern with the child's weight? ☐ Yes ☐ No	**Is there a concern with the child's weight?** ☐ Yes ☐ 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? ☐ Yes ☐ 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?

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

Thank you for your referral. Please fax to 3139 6555.