KYABRAM DISTRICT HEALTH SERVICE

Office Use Only:
UR No. _ _ _ _ _ _

COMMUNITY HEALTH - PAEDIATRIC REFERRAL FOR SERVICES

Childs personal details:

Title: Miss ☐ Master ☐ Mx ☐ Other:	
* D.O.B:	Gender:
* Given name:	
* Family name:	
* Street address:	
	Postcode:
* Contact phone number: Home	Mobile
* Does the child have a current Medicare card?	☐ Yes _ _ _ _ _ _ _ _ _ _ _ _ - _ Expiry date: _ _/ _ _ ☐ No
Does the child have a current Healthcare or Pension card number?	☐ Yes _ _ _ _ - _ _ _ _ - _ _ _ _ ☐ No
Preferred medical practice:	
Preferred General Practitioner:	
Is the child currently attending childcare/pre-school/primary school services?	☐ Yes _ ☐ No

Carer/guardian details:

Title: Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Mx ☐ Other:	
* Given name:	
* Family name:	
* Contact phone number: Home	Mobile
* Relationship to the child:	
* Please confirm that you are a person who makes the child's legal decisions	☐

Details marked with an asterisk (*) need to be completed

Please select what program/therapy:
Please tick one program/therapy each referral sheet

☐ Dietitian	☐ Occupational Therapy	☐ Speech Pathology

Please complete and sign second page

COMM. HEALTH PAEDIATRIC REFERRAL FOR SERVICES CR/015

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KDHS Ver. 1 July 2020

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What are your child's health concerns?
Please help us in helping you by giving us some details about your child's needs

E.g.; communication, speech sounds, self-care, fine motor skills, gross motor skills

What are your child's strengths and interests/games?

Can you please tell us of previous Allied Health services your child has received?
This can be from Kyabram Health or other organisations/private therapists

☐ I currently have a NDIS package/in the process of creating an NDIS package for my child

This form has been made for the community of Kyabram District Health Service for self-referring. Clinicians and Nursing staff will need to complete a ConnectingCare referral or complete the following SCTT tools provided on the Health.Vic website (health.vic.gov.au).

- Consumer Information
- Referral Cover Sheet & Acknowledgement
- Summary & Referral Information
- Consent to Share Information

Practitioners are encouraged to complete a detailed referral letter with client's details.

Please sign and return this document to Kyabram District Health Service or email a copy of this document completed to referrals@kyhealth.org.au

Signature		Date	

For further information about our Community Health Services visit our website - www.kyhealth.org.au