Office use only: Date of Referral:___________ UR:____________ Priority:_____

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CHILD AND FAMILY HEALTH REFERRAL FORM

1. Client Details	
Child's Name:______________________________ **Date of Birth:**_____________ **Address:** ____________________________________	**Gender:** ☐ M ☐ F **Year Starting School:**___________
Parent/Caregiver 1 Name: Relationship to Child: **Address:** **Phone:** **Mobile:** **Email:**	**Parent/Caregiver 2** Name: Relationship to Child: **Address:** **Phone:** **Mobile:** **Email:**
Cultural Background:______________________ Refugee: ☐ Y ☐ N ATSI: ☐ Y ☐ N	**Interpreter required?** Child ☐ Y ☐ N Language:____________ Carer(s) ☐ Y ☐ N Language:____________
Health Care Card: ☐ Y ☐ N **Private Health Ins:** ☐ Y ☐ N	Income assessment (office use only): ☐ high ☐ medium ☐ low
Has the child had a hearing test? ☐ Y ☐ N	**Has the child had a vision test?** ☐ Y ☐ N
Has the child attended relevant maternal child health checks? ☐ 2 years ☐ 3½ years	

2. Referrer contact details	
Name of Referrer:	
Profession:	Agency:
Phone/fax:	Email:

3. **Other Services Involved** eg. GP/Paediatrician/MCHN/Family Services/Private Clinician		
Service/Professional	**Contact details**	**Consent to contact**
		☐ Y ☐ N
		☐ Y ☐ N
		☐ Y ☐ N

Has this child been referred to Early Childhood Early Intervention or NDIS? ☐ Y ☐ N
If yes, not eligible for cohealth

4. Reason for referral		
☐ Speech Pathology	☐ Occupational Therapy	☐ Physiotherapy
☐ Podiatry	☐ Nutrition	☐ Counselling

Main concern:

Level of parental concern:	☐ high	☐ moderate	☐ low	☐ none
Level of referrer's concern:	☐ high	☐ moderate	☐ low	☐ none

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Please describe any concerns in the areas below and rate severity.

MILD: Skills/function a little less advanced or show a minor difference to the child's peers, AND/OR Child needs occasional support from adults to participate in activities.

MODERATE: Skills/function noticeably less advanced or different to child's peers, AND/OR Child needs regular support from adults to participate in activities.

SEVERE: Child has disability/ substantial functional limitations that prevent them from participating in activities in the same way as their peers. **If severe concerns in 2 or more domains please refer to ECEI/NDIS**

Domain 1

Gross Motor **Please Circle** ☐ N/A ☐ Mild ☐ Medium ☐ Severe

eg. delayed milestones: rolling, crawling, walking, balancing, hopping, catching/throwing, coordination (**Postural variations** eg. plagiocephaly , torticollis, DDH, in/out toeing, bow leg, flat foot)

Fine Motor **Please Circle** ☐ N/A ☐ Mild ☐ Medium ☐ Severe

eg. pencil grasp; cutting; drawing; using two hands in activities; hand preference; grasping objects

Sensory **Please Circle** ☐ N/A ☐ Mild ☐ Medium ☐ Severe

eg. under/over responsive to noise, touch, movement, or light; clumsy; fidgety; avoids playing on playground equipment/swings; understanding and interpreting visual information

Self Care **Please Circle** ☐ N/A ☐ Mild ☐ Medium ☐ Severe

eg. toileting; self-feeding; saliva control; using cutlery; dressing

Eating **Please Circle** ☐ N/A ☐ Mild ☐ Medium ☐ Severe

eg. fussy eating; mealtime routines; slow growth; bowel issues; nutrient deficiency

Domain 2

Communication **Please Circle** ☐ N/A ☐ Mild ☐ Medium ☐ Severe

eg. understanding language; using words and language; speaking clearly, voice; fluency (stuttering);

Cognition /Play **Please Circle** ☐ N/A ☐ Mild ☐ Medium ☐ Severe

eg.; thinking, ideas, learning skills; problem solving, play skills / limited types of play; limited interests;

Domain 3

Social/Emotional **Please Circle** ☐ N/A ☐ Mild ☐ Medium ☐ Severe

eg. turn taking; social interactions; eye contact; compliance; tantrums; social & emotional regulation parenting support; social isolation; challenging family circumstances; family violence/traumas;

Attention/Behaviour **Please Circle** ☐ N/A ☐ Mild ☐ Medium ☐ Severe

eg. aggressive or disruptive behaviours; separation; withdrawn; impulse control; easily distracted;

5. Parent/Carer's Signature: Date:

6. Contact – Please return to *cohealth service access*

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