



**REFERRAL
ELLEN BARRON FAMILY CENTRE**

Phone: 07 3139 6500
Facsimile: 07 3139 6555

(Affix patient identification label here)

URN: _____ Sex: M F
Family Name: _____
Given Names: _____
Address: _____
Date of Birth: _____ Telephone: _____

REFERRING AGENT DETAILS

Name: _____ Position: _____ Date of Referral: ___/___/___
Organisation Name: _____
Address: _____ Postcode: _____
Telephone: _____ Fax: _____ Email: _____

DETAILS OF PARENTS

UR NUMBER: _____ (Office Use Only) To be admitted for intervention: Yes <input type="checkbox"/> No <input type="checkbox"/> To be admitted as boarder: Yes <input type="checkbox"/> No <input type="checkbox"/>	UR NUMBER: _____ (Office Use Only) To be admitted for intervention Yes <input type="checkbox"/> No <input type="checkbox"/> To be admitted as boarder Yes <input type="checkbox"/> No <input type="checkbox"/>
Family Name: _____ Other/previous Name: _____ Given Names _____ DOB ___/___/___ Age _____ Country of Birth _____ Address _____ Postcode _____ Phone (H) _____ (W) _____ (Mob) _____ Email _____ Married/ Defacto/Single/Separated: _____ Indigenous Status: _____	Family Name: _____ Other/previous Name: _____ Given Names _____ DOB ___/___/___ Age _____ Country of Birth _____ Address _____ Postcode _____ Phone (H) _____ (W) _____ (Mob) _____ Email _____ Married/ Defacto/Single/Separated: _____ Indigenous Status _____

CHILD/CHILDREN WITH PRESENTING CONCERN REQUIRING INTERVENTION (Can only admit children 0 to 3 YEARS OF AGE for intervention see below for boarder admissions of siblings)

1. UR NUMBER: _____ (Office Use Only) Family Name: _____ Given Names: _____ DOB: ___/___/___ Age: _____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F Indigenous Status: _____ Country of Birth: _____ Address: _____ Postcode _____ Bottle fed <input type="checkbox"/> Breast fed <input type="checkbox"/> On solids <input type="checkbox"/> Bassinet <input type="checkbox"/> Cot <input type="checkbox"/> Bed <input type="checkbox"/> Please list medications: _____ Birth weight: _____ Present weight: _____	2. UR NUMBER: _____ (Office Use Only) Family Name: _____ Given Names: _____ DOB: ___/___/___ Age: _____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F Indigenous Status: _____ Country of Birth: _____ Address: _____ Postcode _____ Bottle fed <input type="checkbox"/> Breast fed <input type="checkbox"/> On solids <input type="checkbox"/> Bassinet <input type="checkbox"/> Cot <input type="checkbox"/> Bed <input type="checkbox"/> Please list medications: _____ Birth weight: _____ Present weight: _____
NEXT OF KIN Name: _____ Address: _____ Telephone: _____ Relationship: _____	NEXT OF KIN Name: _____ Address: _____ Telephone: _____ Relationship: _____

DO NOT WRITE IN THIS BINDING MARGIN

Referral

PARENT/CARER INFORMATION

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

Has the parent sought help about this current issue Yes No

Comment

Do you consider there are any issues of risk? *(if there are identified issues of risk please provide details in order that the referral can be processed promptly without delay)*

None

Child Protection Concerns

Disclosed harming the baby _____

Thoughts of harming the baby _____

Mental Health Issues

Thoughts of self harm _____

Drug and/or alcohol abuse _____

Domestic Violence

Domestic violence _____

Current Safety Plan: _____

Other relevant parent/carer information?

Current medication: _____

Interpreter required: _____

Disability aids required: _____

Is the parent aware of the information provided? Yes No

If not why? _____

Is the parent in agreement with the referral? Yes No

If not why? _____

ALERT

While medical officers and registered nurses are mandated to report abuse and neglect to statutory authorities, all referring parties have a duty of care to ensure the safety and protection of children and young people from physical, psychological, or emotional harm. Where child protection concerns have been identified contact the Department of Child Safety in your local area, or Crisis Care after hours on 3235 9999 or 1800 177 135

DO NOT WRITE IN THIS BINDING MARGIN


Version and date here V2 - 7.11.08

Please ensure Genogram is completed

Genogram

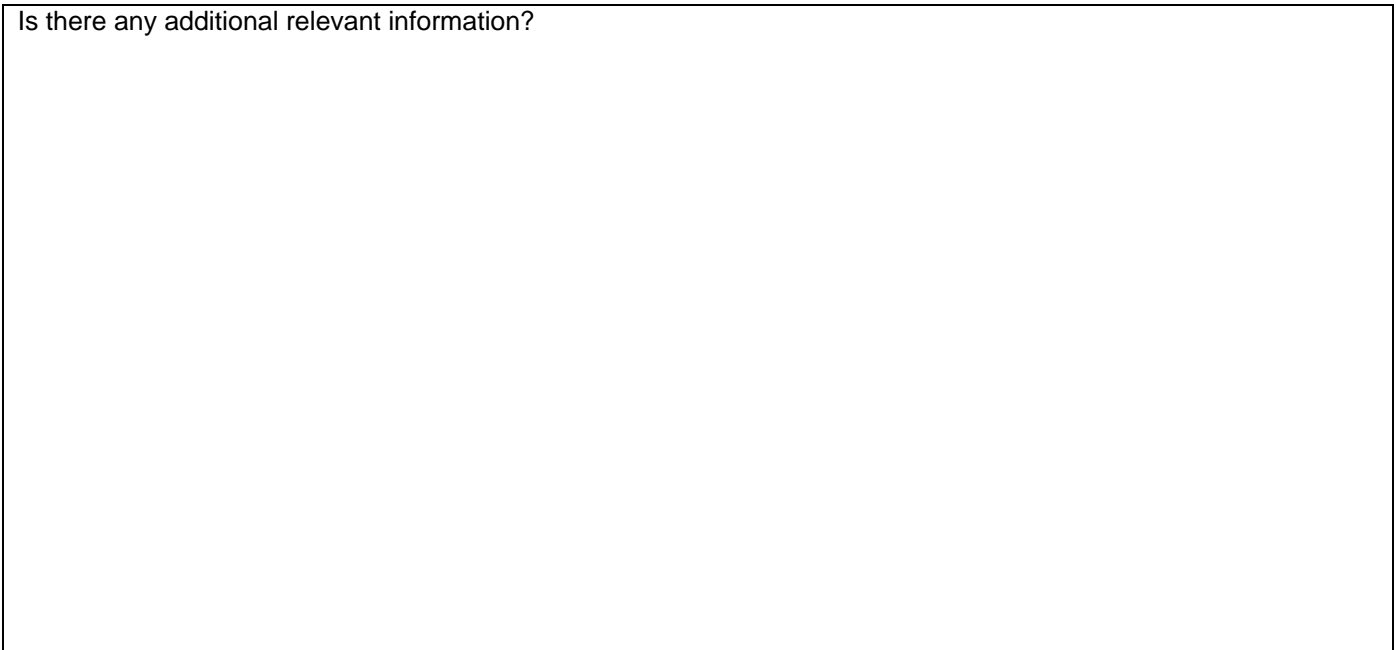
Legend

- Male (placed left)
- Female (placed right)
- | Offspring's
- △ Unknown
- Death
- // Divorce
- / Separation



DO NOT WRITE IN THIS BINDING MARGIN

Is there any additional relevant information?



PLEASE ENSURE ALL DETAILS ARE COMPLETED ON ALL 4 PAGES FOR PROMPT ASSESSMENT OF THE REFERRAL

SIGNATURE: _____ DATE: _____