WHAH433

Western Health

Paediatric Allied Health
Referral Form
Ph: 8345 1727 Fax: 9055 2125

OFFICE USE ONLY

Child's Details			
Child's First Name		**Child's Surname**	
Date of Birth		**Gender**	☐ Male ☐ Female
Address			**Postcode**
Is the child of:	☐ Aboriginal origin ☐ Torres Strait Islander origin ☐ Both ATSI ☐ Neither		
Country of Birth		**Interpreter required**	☐Yes, ☐ No Language:
Medicare Number:			

Parent / Carer's Contact Details:			
Carer 1: Name		**Carer 2: Name**	
Relationship to child		**Relationship to child**	
Phone Number		**Phone Number**	
Interpreter required:	☐Yes ☐ No Language:	**Interpreter required**	☐Yes ☐ No Language:

Clinic or speciality required (select as many as required):

- ☐ Physiotherapy
- ☐ Speech pathology
- ☐ Nutrition and Dietetics
- ☐ Occupational Therapy
- ☐ Neuropsychology
- ☐ Social Work
- ☐ Audiology

Referral Reason: (attach separate reports if further detail required)

Presenting problem (list main areas of concern):

Impact on patient:

Diagnosis/provisional diagnosis:

Other relevant information (i.e. Medical /Developmental / Social History including custody arrangements or court orders pertaining to child).

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Professionals / Services : ***Provide details of other services involved with this child***		
General Practitioner:	Name: Clinic:	Phone:
Paediatrician	Name: Clinic:	Phone:
Other services (Include health professionals, early intervention, NDIS etc.)	Service name: Date referred:	Phone:
	Service name: Date referred:	Phone:

Details of professional completing this application	
Name of referrer	
Position / Profession	
Agency / Service	
Contact (Phone, fax)	

Parent/Guardian Consent: (Verbal consent should only be used where it is not practicable to obtain written consent.)

☐ *This referral has been explained to me and I give consent for this to be forwarded to Western Health*

☐ *I agree that the services listed on this form may be contacted about this referral*

☐ *I consent for appropriate information to be shared with Early Childhood Early Intervention/NDIS*

☐ *I consent for appropriate professionals to be contacted as required*

Signed*:* _____ Date: ___ /___ /_____ ☐ Verbal Consent

Send completed form to:

Women's and Children's Specialist Clinics Referral Management Centre
Fax: _____

Privacy statement: *The information collected is recorded for planning and provision of Western Health services. It will be maintained in accordance with the Public Records Act 1998, stored in a secure place and will be accessible only to authorised workers of Western Health. It will not be used for other purposes without first obtaining your consent unless there is a legal requirement to do so.*