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| http://dchintranet.infoxchange.net.au/sites/default/files/yourcomhealth_col_logo.png | **CHILD, YOUTH AND FAMILY TEAM – REFERRAL FORM****Children aged 0-6 years** |
| **The Your Community Health Child, Youth and Family team provides services to children, birth to school age, with mild to moderate difficulties. If you feel this child has more significant delays in their development, please consider a referral to a paediatrician and/or to the National Disability Insurance Scheme (NDIS).** |
| **Child’s Given Name:**      | **Child’s Family Name:**       | **Date of Birth:**     |  **Gender:**  |
| **Address:**      **Suburb:**        | **Postcode:** |
| **Parent / Carer # 1**  | Name:      Relationship to child:       | **Contact Numbers:** Home:      Mobile:      |
| **Parent / Carer # 2** | Name:      Relationship to child:       | **Contact Numbers:** Home:      Mobile:      |
| **Language(s) spoken at home:**      Interpreter Required: [ ]  Yes [ ]  No Language required:       | **Indicate if:**[ ]  Aboriginal: [ ]  Torres St Is.  |
| Are there any court orders regarding this child? [ ]  Yes [ ]  No Are there any indicators or history of family violence? [ ]  Yes [ ]  No If so, please describe.        |
| Are there any stressors impacting on the family? *(e.g. parental separation, moving house, serious illness, etc)* If so, please describe.       |
| Name of Maternal and Child Health Nurse:      Name of Childcare:      Name of Kindergarten:       [ ]  3 year old kinder [ ]  4 year old kinderIs the child attending school next year?  |
| Is the family involved with any other health professionals or specialists (past or current)? (eg. Paediatrician, Allied Health Professional, Audiologist) [ ]  Yes [ ]  No Type of Service Contact Name Contact number                                                                     |
| **Referral to:** [ ]  Counselling [ ]  Dietetics [ ]  Occupational Therapy [ ]  Physiotherapy[ ]  Podiatry [ ]  Speech Pathology [ ]  Paediatrician (GP referral required)[ ]  Feeding Clinic (Speech Pathology & Dietetics) |
| **Reason for Referral:** What are the main concerns for this child?       |
| Has the child had their hearing tested? [ ]  Yes [ ]  No Has the child had their vision tested? [ ]  Yes [ ]  NoHas the child had a hip ultrasound? (if applicable) [ ]  Yes [ ]  NoBrigance test attached? (if applicable) [ ]  Yes [ ]  No |

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| Developmental Profile |
| Please indicate if there are concerns in the following areas:  |
| INDEPENDENCE & DIET(Daily life activities)[ ]  Yes [ ]  No *The child has difficulty with:* | **FINE MOTOR** **(Small movements of hands)****[ ]  Yes [ ]  No*****The child has difficulty with:*** | **GROSS MOTOR & FEET** **(Whole body movements)** **[ ]  Yes [ ]  No*****The child has difficulty with:*** |
| [ ]  Dressing[ ]  Toileting[ ]  Organising self [ ]  Growth & Weight[ ]  Feeding (using cutlery/cup, food refusal, texture progression, etc.) [ ]  Adequate nutrition [ ]  Other       | [ ]  Grasping small items[ ]  Holding a pencil/crayon[ ]  Using scissors[ ]  Using two hands together[ ]  Completing puzzles[ ]  Copying actions[ ]  Copying drawings[ ]  Other       | [ ]  Rolling[ ]  Sitting[ ]  Crawling[ ]  Walking[ ]  Jumping[ ]  Hopping[ ]  Climbing[ ]  Ball skills[ ]  Balance[ ]  Co-ordination | [ ]  Trips/falls often[ ]  Walking on toes[ ]  Ankles or feet rolling in/out [ ]  In-toeing/ out-toeing[ ]  Bow legs/ knock knees[ ]  Stiff or floppy muscles[ ]  Flat spot on head[ ]  Other       |
| PLAY & SOCIAL DEVELOPMENT[ ]  Yes [ ]  No*The child has difficulty with:* | **LANGUAGE & TALKING****[ ]  Yes [ ]  No*****The child has difficulty with:*** | **BEHAVIOUR & EMOTIONS****[ ]  Yes [ ]  No*****The child has difficulty with:*** |
| [ ]  Occupying self in play[ ]  Taking turns[ ]  Sharing[ ]  Eye contact[ ]  Interacting with others[ ]  Playing alongside or withanother child[ ]  Pretend play[ ]  Other       | [ ]  Speech sounds[ ]  Understanding instructions[ ]  Using words or sentences[ ]  Stuttering [ ]  Using a good quality voice [ ]  Social communication[ ]  Other       | [ ]  Tantrums[ ]  Managing feelings[ ]  Calming self [ ]  Coping with changes in routine[ ]  Strong reactions to sensory input  (noise, movement and tactile input etc)[ ]  Attention and concentration[ ]  Other       |

**Referrer Details**

Name:

Position:

Organisation:

Address:

Phone:      Fax:

Email address:

Date of Referral: Click here to enter a date.