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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 kinder  Is 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  No  Has the child had a hip ultrasound? (if applicable)  Yes  No  Brigance 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 with  another 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.