Facility: COM HKH MQE MVH RNS RYD

| This PDF | will expire on | 1 May 2025 |
|----------|----------------|------------|
|          |                |            |

| FAMILY NAME                |  | MRN      |           |  |
|----------------------------|--|----------|-----------|--|
| GIVEN NAME                 |  | MALE     | FEMALE    |  |
| D.O.B. DD / MM / YYYY M.O. |  | О.       |           |  |
| ADDRESS                    |  |          |           |  |
|                            |  |          | PH        |  |
| M/C FIN                    |  |          |           |  |
| LOCATION / WARD            |  | ADM DD / | MM / YYYY |  |

#### COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

### REFERRAL TO CHILD **DEVELOPMENT SERVICE**

The Child Development Service (CDS) is a tertiary assessment service reserved for children with complex developmental problems, especially emerging intellectual disability. We provide a range of assessment and/or consultation services, depending on the child and their situation.

Most developmental concerns are managed by local health professional (Paediatrician, Allied Health Therapist, Child & Family Health Nursing) without needing an assessment by CDS.

Eligibility to the CDS: Children who have not yet started school and reside within the Northern Sydney Local Health District and have a Medicare card.

To make a referral a clinician or early childhood professional to complete this form in detail outlining behaviours consistent with a global development delay or developmental disability

Intake and Triage: Information from this form and related attachments will be assessed by our team to determine access, priority, and alternative service pathways.

Outcome: Referrers and the family will be advised of the referral outcome by email.

| Referrer Details  |   |
|---|---|
| Name  | Profession                                  |
| Email   | Phone                                       |
| Mailing address   |   |
| Date://   |   |
| Child Details   |   |
| Family name   | Given name                                  |
| Date of birth:/   | Sex: Male Female                            |
| Address   | Postcode                                    |
| Aboriginal or Torres Strait Islander Origin? Aboriginal | Torres Strait Islander Both Neither Unknown |
| Interpreter required: Yes No Language                   |   |
| Parent/Carer Details                                    |   |
| Parent/Carer 1 name                                     | Relationship to child                       |
| PhoneEmail  |   |
| Interpreter required: Yes No Language                   |   |
| Parent/Carer 2 name                                     | Relationship to child                       |
| Phone Email   |   |
| Interpreter required: Yes No Language                   |   |

CATALOGUE NUMBER NS10806-E APR24/V4

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|-----------------------|-----|-----|------------|-----------|
| GIVEN NAME            |     |     | MALE       | FEMALE    |
| D.O.B. DD / MM / YYYY | М.0 | О.  |            |           |
| ADDRESS               |     |     |            |           |
|                       |     |     | PH         |           |
| M/C                   |     | FIN |            |           |
| LOCATION / WARD       |     |     | ADM DD / I | MM / YYYY |

|  | COMPLETE ALL DETAILS                      | OR AFFIX PATIENT L   | ABEL HE    | RE         |
|--|---|----------------------|------------|------------|
| Additional Care Arrangements   |   |                      |            |            |
| Is there current Department Communities and Justic   | ce (DCJ) or Out of Home Care (OOHC) invo  | olvement?            | Yes        | No         |
| If yes, who has Parental Responsibility?   |   |                      |            |            |
| Is this a Kinship Care arrangement?  |   |                      | Yes        | No         |
| Case Worker name   | Contact                                   |                      |            |            |
| Has the Parent/Carer consented to this referral?   |   |                      | Yes        | No         |
| Does the child have any existing <b>Developmental Dia</b> If yes, please specify:                                    | ngnosis?:                                 |                      | Yes        | No         |
| <b>Developmental Concern(s)</b> tick any that may possik   | oly apply to this child:                  |                      |            |            |
| Global Developmental Delay   | Intellectual Disability                   | Autism Spectrum Di   | isorder    |            |
| Fetal Alcohol Spectrum Disorder  | Other diagnosis                           |                      |            |            |
| If other, please specify:  |   |                      |            |            |
| What is your main concern?  Does the carer share your concerns?  Has the child previously had a Developmental or Co. | gnitive assessment?                       | Yes No               | Yes<br>Unk | No<br>nown |
| If yes, date of assessment:// Outcome:   |   |                      |            |            |
| Outcome.   |   |                      |            |            |
| Current Skills   |   |                      |            |            |
| Expressive Language/Communication (e.g. no words   |   |                      | ing etc.)  |            |
| Receptive Language (e.g. follows one part or comple  | ex instructions, understands gestures, re | sponas to name etc.) |            |            |



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| ADDRESS                    |     |      |           |
|                            |     | PH   |           |
| M/C FIN                    |     |      |           |
| LOCATION / WARD            |     |      | M / YYYY  |
|                            | M.C |      | MALE M.O. |

### **REFERRAL TO CHILD DEVELOPMENT SERVICE**

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE Play and socialisation (e.g. pretend play, initiates interaction, interest in peers, parallel play)

| Gross motor skills (e.g. strength, coordination, agility)  |             |
|--|-------------|
|  |             |
|  |             |
|  |             |
|  |             |
| Fine motor skills (e.g. drawing, construction play, table top skills, handedness etc.)                       |             |
|  |             |
|  |             |
|  |             |
|  |             |
|  |             |
|  |             |
| Behaviour concerns (e.g. tantrums, fixations, repetitive behaviours, strong emotions, safety awareness etc.) |             |
|  |             |
|  |             |
|  |             |
| Self-help Skills (e.g. dressing, toileting, use of cutlery etc.)   |             |
| Seti-fieth Skills (e.g. diessing, tolleting, use of cuttery etc.)  |             |
|  |             |
|  |             |
|  |             |
|  |             |
| Pre-academic skills (e.g. colours, puzzles, letters, numbers etc.)   |             |
| V. C   |             |
|  |             |
|  |             |
|  |             |
| MARGIN - NO WRITING  | Page 3 of 4 |



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| ADDRESS               |     |     |            |          |
|                       |     |     | PH         |          |
| M/C                   |     | FIN |            |          |
| LOCATION / WARD       |     |     | ADM DD / M | M / YYYY |

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

| Background Medical History (including hearing or vision tests)                                      |             |         |                 |  |
|---|-------------|---------|-----------------|--|
|   |             |         |                 |  |
|   |             |         |                 |  |
|   |             |         |                 |  |
|   |             |         |                 |  |
|   |             |         |                 |  |
| Relevant Psychosocial/Family Histor   |             |         |                 |  |
| (e.g. parental situation, wellbeing, social di  | ısadvantage | s, othe | er challenges)  |  |
|   |             |         |                 |  |
|   |             |         |                 |  |
|   |             |         |                 |  |
|   |             |         |                 |  |
| Current Services Involved   |             |         |                 |  |
| Service   | Yes/No      |         | Name of Service |  |
| Occupational Therapy  | Yes         | No      |                 |  |
| Speech Pathology  | Yes         | No      |                 |  |
| Physiotherapy   | Yes         | No      |                 |  |
| Social Work/Psychology  | Yes         | No      |                 |  |
| Childcare/Preschool   | Yes         | No      |                 |  |
| Paediatrician   | Yes         | No      |                 |  |
| Non-government organisation/family support service  | Yes         | No      |                 |  |
| Other   | Yes         | No      |                 |  |
| NDIS funding  | Yes         | No      |                 |  |
| Applied   |             |         |                 |  |
| Do you have existing reports or letters you can attach to this referral?  Yes No                    |             |         |                 |  |
| Additional comments or considerations before before the intake clinician contacts the parent/carer? |             |         |                 |  |
|   |             |         |                 |  |
|   |             |         |                 |  |
|   |             |         |                 |  |
|   |             |         |                 |  |

#### Thank you for completing this form. Please email completed referral form to NSLHD-CDS@health.nsw.gov. auchieu for a completing this form. Please email completed referral form to NSLHD-CDS@health.nsw.gov. auchieu for a complete for a complete

If you have any queries, please contact the Child Development Service on the above email or call on (02) 9462 9288. Website: https://www.nslhd.health.nsw.gov.au/CYFH/services/Pages/ChildDevelopmentalService.aspx