



Facility: COM HKH MQE MVH RNS RYD

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

COMMUNITY PAEDIATRIC CLINIC REFERRAL

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Child's family name Given name

Address

..... Suburb Postcode

Date of Birth: ___ / ___ / ____ Age: Sex: Male Female

Mobile phone Home phone

Medicare No No of child Expiry Date: ___ / ___ / ____

Parent/Carer 1 Age

Email Occupation

Mobile phone Home phone

Parent/Carer 2 Age

Email Occupation

Mobile phone Home phone

Living arrangement: Both Parents Single parent Parental separation OOHC/Kinship Care

Siblings and ages

Language(s) other than English Interpreter needed: Yes No

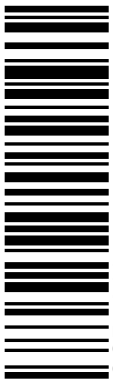
General Practitioner: (if not the referrer)

Address and contact details

Priority Populations (please tick all relevant as this will assist us in prioritising appointments)

- Exposure to family violence
- Family/carer drug and alcohol concerns or history
- Family/carer mental health concerns or history
- Involvement of Department Communities & Justice (DCJ) or other family support service (eg Benevolent Society/Catholic Care)
- Socioeconomic disadvantage (e.g. Health care card)
- Refugee or asylum seeker
- Aboriginal or Torres Strait Islander

Main concerns:



COR5244

Holes punched as per AS2828.1:2019

BINDING MARGIN - NO WRITING

CATALOGUE NUMBER NS12841-E JUL23/V1

REFERRAL - COMMUNITY PAEDIATRIC CLINIC



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Is the child seeing, or have they seen a Paediatrician for this concern? If yes, name and address of Paediatrician:	Yes	No
Are there other services involved in helping this child? (Details, including contact phone, therapists, specialists etc.)		
Please attach any other information you have that is relevant to this referral (reports or letters, school reports).		
Referrer Name	Signature	
Address		
Provider No	Date: ___ / ___ / ____	
<p>Please complete ASAP so we can process your referral and return to:</p> <p>North Shore Ryde Child and Family Health Service Level 2, 2C Herbert Street, St Leonards, NSW 2065 Tel 02 9462 9200 Fax 02 9462 9085 Email: NSLHD-CFHNSR@health.nsw.gov.au</p> <p>Dalwood Community Child & Family Health Service 21 Dalwood Ave, Seaforth, NSW 2092 Tel 02 9951 0300 Fax 02 9951 0390 Email: NSLHD-NB-Admin-CommunityPaediatrics@health.nsw.gov.au</p> <p>Hornsby Ku-ring-gai Child and Family Health Service Ground Floor, Palmerston Building (Building 17), Hornsby Ku-ring-gai Hospital, Gate 5 Derby Road, Hornsby, NSW 2077 Tel 02 9485 7533 Fax 02 9485 7519 Email: NSLHD-HornsbyCHC@health.nsw.gov.au</p>		

Holes punched as per AS2828.1:2019
BINDING MARGIN - NO WRITING