Northern Sydney
Local Health District

This PDF will expire on 1 August 2024

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

Facility: COM HKH MQE MVH RNS RYD

COMMUNITY PAEDIATRIC CLINIC REFERRAL

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

COR5244

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:

Holes punched as per AS2828.1:2019

BINDING MARGIN – NO WRITING

REFERRAL – COMMUNITY PAEDIATRIC CLINIC

CATALOGUE NUMBER NS12841-E JUL23/V1

Northern Sydney
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COMMUNITY PAEDIATRIC CLINIC REFERRAL

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COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Is the child seeing, or have they seen a Paediatrician for this concern? ☐ Yes ☐ No
If yes, name and address of Paediatrician:

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: __ / __ / ____

Please complete ASAP so we can process your referral and return to:

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

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

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

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