Child and Family Health Service (CaFHS)

REFERRAL FORM

(PAGE 1) - CLIENT DETAILS

CHILD PATIENT LABEL	CAREGIVER PATIENT LABEL
ID Number:	ID Number: ....
Surname:	Surname: ....
Given Names:	Given Names: ....
D.O.B: .... Sex:	D.O.B: .... Sex: ....

EMAIL completed Referral Form to Health.ReferralstoCaFHS@sa.gov.au

REFERRAL DETAILS – Referrer to complete TICK FOR EACH PAGE SENT FOR THIS REFERRAL: Page 1 ☐ Page 2 ☐ Page 3 ☐

Reason for Referral ☐ Birth Referral ☐ Other (specify)............ Date .... /......... /..........

Hospital for Birth / admission ....

Baby's / Child's discharge date .... /......... /..........

Referring Hospital / Organisation / Person .... Contact phone ....

Additional documents sent with referral ☐ No ☐ Yes (specify)............

BIRTH INFORMATION – Hospital staff to complete

Gestation .... weeks **Birth Weight** .... grams **APGAR** 1 min .... 5 min ....

Hearing Screening Required ☐ Yes ☐ No **Reason:** ☐ No Screen ☐ Referred Screen

Midwifery service visiting ☐ Yes ☐ No Service .... **Baby's / Child's discharge date** .... /......... /..........

CONTACT DETAILS – Caregiver to complete

CAREGIVER (primary contact person)

Relationship to Child .... First child ☐ Yes ☐ No

Family Name .... Previous Name ....

Given Name .... Middle Name ....

Date of Birth .... /......... /......... Sex ☐M ☐F ☐Other

Do you identify as ☐ Aboriginal ☐ Torres Strait Islander ☐ Both Aboriginal and Torres Strait Islander ☐ N/A

Country of Origin ☐ Australia ☐ Other (specify) ....

Arrived in Australia within the last 3 months ☐ Yes ☐ No If Yes, from which Country ....

Interpreter Required? ☐ Yes ☐ No Language other than English spoken at home ....

CONTACT DETAILS

Residential Address ....

Suburb .... State .... Postcode ....

Postal Address (if different)............

Preferred Method(s) *Tick all that apply and provide details* Home Tel .... Work Tel ....

☐ Mobile / Phone number............ (prefer ☐ SMS ☐ Call)

☐ Email ....

CHILD Complete the details for each child requiring referral

Family Name .... Date of Birth .... /......... /.........

Child 1 Given Name .... Middle Name .... Sex ☐M ☐F ☐Other

Child 2 Given Name .... Middle Name .... Sex ☐M ☐F ☐Other

Child 3 Given Name .... Middle Name .... Sex ☐M ☐F ☐Other

Is child identified as ☐ Aboriginal ☐ Torres Strait Islander ☐ Both Aboriginal and Torres Strait Islander ☐ N/A

CaFHS is part of the Women's and Children's Health Network and is dedicated to person and family centred care.
At the centre of CaFHS approach is the child achieving the best possible health, development and wellbeing outcomes.

Consent to CaFHS provided? ☐ Yes ☐ No Date ...... /..... /..... **Consent to hearing? ☐ Yes ☐ No**

Glossary: ID - Identification, DOB - Date of Birth, SMS - Short Message Service, M - Male, F Female, N/A - Not applicable. Information contained in this referral form may be private and confidential and may also be subject of legal professional privilege or public interest protections. If you are not the intended recipient, any use, disclosure, or copying of this document is unauthorised, and in certain circumstances may constitute an offence. If you have received this document in error, please contact the referrer.

D 7676 July 2023 Version 2.4

Child and Family Health Service (CaFHS)

REFERRAL FORM

(PAGE 2) - ADDITIONAL INFORMATION - CHILD

COMPLETE ONE PAGE PER CHILD

CHILD PATIENT LABEL

ID Number:.................................. ....

Surname: ....

Given Names:...

D.O.B:..Sex: ....

CHILD SITUATION AND BACKGROUND – Referrer to complete if required

TICK FOR EACH PAGE SENT FOR THIS REFERRAL: Page 1 ☐ Page 2 ☐ Page 3 ☐

Area(s) of Concern ☐ Growth ☐ Health ☐ Prematurity ☐ Breastfeeding ☐ Development

☐ Congenital Abnormality ☐ Psychosocial

☐ Child Protection ☐ Other (specify) ....

Multi-Resistant Organism (MRO) ☐ MRSA ☐ VRE ☐ Other (MRO) (specify): ....

☐ CARL Notification Made (add report # if known)...

☐ Section 41 (please provide carer and DCP case worker details below) ....

Please provide details and context of concerns, protective factors, care requested, and other service agencies referred to or involved in care

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Is a priority visit required? ☐ Yes ☐ No

Is the Caregiver aware of the referral information shared? ☐ Yes ☐ No

If NO answered, please provide more information ....

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Name .... Signature .... Designation ....

Date .... /.......... /.......... Ward .... Contact # ....

DEPARTMENT CHILD PROTECTION INVOLVMENT

DCP C3 Number .... Medicare Number ....

Date child's Guardianship order commenced .... /.......... /......... Date child's Guardianship order will expire .... /.......... /.........

Type of Order ....

Current Placement Type ....

DCP Case Worker .... Contact Phone ....

DCP Team Supervisor ....

Principal Aboriginal Consultant ....

Responsible DCP Office ....

Glossary: ID - Identification, DCP - Department for Child Protection, C3 - the DCP identity number, CARL - Child Abuse Report Line DOB - Date of Birth, MRSA - Methicillin-resistant Staphylococcus aureus, VRE-Vancomycin-resistant Enterococcus. Information contained in this referral form may be private and confidential and may also be subject of legal professional privilege or public interest protections. If you are not the intended recipient, any use, disclosure, or copying of this document is unauthorised, and in certain circumstances may constitute an offence. If you have received this document in error, please contact the referrer.

REFERRAL FORM CLIENT INFORMATION

Child and Family Health Service (CaFHS)

REFERRAL FORM

(PAGE 3) - ADDITIONAL INFORMATION - CAREGIVER

COMPLETE ONE PAGE PER CAREGIVER

CAREGIVER PATIENT LABEL

ID Number:.. ....

Surname:..

Given Names:..

D.O.B:...Sex: ....

CAREGIVER SITUATION AND BACKGROUND - Referrer to complete if required

TICK FOR EACH PAGE SENT FOR THIS REFERRAL: Page 1 ☐ Page 2 ☐ Page 3 ☐

Area(s) of Concern
☐ Mental Health ☐ Disability ☐ Health Issues ☐ Birth Trauma ☐ Support / Isolation
☐ Family Conflict ☐ Child Protection ☐ Housing ☐ Alcohol Use in Pregnancy
☐ Drug Use in Pregnancy ☐ Current Alcohol / Drug Abuse ☐ Smoking in Pregnancy
☐ Domestic and Family Violence ☐ Breastfeeding
☐ Other (specify) ....
Multi-Resistant Organism (MRO) ☐ MRSA ☐ VRE ☐ Other (MRO) (specify): ....

ANRQ Completed Date .... /........ /........ ANRQ Score ....

EPDS Completed Date .... /........ /........ EPDS Score ....

Please provide details and context of concerns, protective factors, care requested, and other service agencies referred to or involved in care

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Is a priority visit required? ☐ Yes ☐ No

Is the Caregiver aware of the referral information shared? ☐ Yes ☐ No

If NO answered, please provide more information ....

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Name .... Signature .... Designation ....

Date .... /.......... /.......... Ward .... Contact ....

ANTENATAL REFERRALS ONLY – Referrer to complete in conjunction with situation and background if required

Expected Delivery Date .... /.......... /.........

Antenatal Service Involved in care ....

Contact Person .... Contact Phone ....

Antenatal Service Involved in care ....

Contact Person .... Contact Phone ....

Reason for Antenatal Referral ....

....

Please attach copy of ANRQ to referral if appropriate

Glossary: ID - Identification, ANRQ - Antenatal Risk Questionaire, EPDS - Edinburgh Postnatal Depression Scale, DOB - Date of Birth, M - Male, F - Female, N/A - Not applicable. Information contained in this referral form may be private and confidential and may also be subject of legal professional privilege or public interest protections. If you are not the intended recipient, any use, disclosure, or copying of this document is unauthorised, and in certain circumstances may constitute an offence. If you have received this document in error, please contact the referrer.

REFERRAL FORM CAREGIVER INFORMATION

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