**WCH Outpatient Referral: CHILD DEVELOPMENT UNIT**

**Fax completed form to: 08 8161 6099**

Telephone (08) 8161 7287 Fax: (08) 8161 6099 email: Health.CDU@sa.gov.au

WCH Website OPD information: [https://www.wch.sa.gov.au/professionals/referrals-to-outpatient-clinics](https://aus01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.wch.sa.gov.au%2Fprofessionals%2Freferrals-to-outpatient-clinics&data=05%7C01%7CHelen.Parry%40sa.gov.au%7C8d3559969a9642ad45fe08daabd71526%7Cbda528f7fca9432fbc98bd7e90d40906%7C1%7C0%7C638011237569322766%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=WPc4MhN4KSiZ1DdlKozUUV2nNBltdHqXZEJAWFAbyb0%3D&reserved=0)

Child Development Unit information: [Women’s and Children’s Hospital • Child Development Unit (wch.sa.gov.au)](https://www.wch.sa.gov.au/patients-visitors/children/care-and-support/child-development-unit?token=M4V1v3ULSwONPB5bJ7I98BS-yFEI_LWf)

**WCH Clinic required: CHILD DEVELOPMENT UNIT**

Date:

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| **Patient Details** | Name:  Address:  Phone: | Age:  Date of Birth:  Sex:  Gender Identity: |
| Medicare details | Medicare No.: | Medicare Expiry Date: |
| q Family do not have Medicare  *Non-Medicare Families Please note that charges apply to services provided to patients who do not hold a Medicare Card. If the family does not have a Medicare Card, please contact the hospital’s finance team on 8161 7390 to discuss likely costs.* | | |
| Parent/ Carer/ Legal Guardian 1 | Name:  Phone:  Email:  Address (If different to above): | Relationship to child:  Consents to referral:  q Yes  q No |
| Parent/ Carer/ Legal Guardian 2 | Name:  Phone: | Relationship to child: |
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| **Priority Groups** | Is this patient of Aboriginal and/ or Torres Strait Islander origin? | q Yes  q No |
|  | Is this patient under the Guardianship of the Minister? | q Yes  q No |
|  | DCP case worker (if known):  Name: | DCP contact details/ Office: |
| **Interpreter Required** | q Yes  q No | Language: |
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| **Catchment area**  Acceptance of referrals is subject to catchment areas which are defined for the three assessment units.  Please refer to the catchment map to determine which is the appropriate assessment unit to refer to  (last page of this referral form). If you are unsure please call CDU if you are unsure.  Please do not refer to multiple units at once.  For children residing outside of the Adelaide metropolitan area, referrals will be reviewed taking into  consideration child developmental assessment services available for the region.  ☐ SOUTH Flinders Medical Centre Child Assessment Team (8204 4433) Age Limit: up to 14 years  ☐ NORTH Gordon McKay Child Development Unit (7485 4109) Age Limit: up to 8 years  ☐ CENTRAL Women’s and Children’s Hospital Child Development Unit (8161 7287) Age Limit: up to 18 | | |

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| **Referring Doctor:** | Name:  Qualifications:  Provider Number: | Practice Name and Address: |
| Phone: | Fax: | Practice Email: |
| Referring Doctor's signature: |  | Date: |
| \*\*MEDICAL PROFESSIONALS PLEASE SELECT ONE PAEDIATRICIAN\*\*  Next available appointments are allocated  Dear Dr  ☐ JEYASEELAN (Medical Unit Head) ☐ TIDEMANN ☐ WHITE  ☐ BAULDERSTONE ☐ ROSSER ☐ LEE ☐ NOZZA | | |
| **Who can refer to CDU?**  PLEASE NOTE: If a child is referred by an allied health professional or educator, the CDU process can  begin, however during the process if a paediatric appointment is required, the family will require a  GP referral.  ☐ Medical Professionals (General Practitioners, Paediatricians, Medical Officers, Specialists)  ☐ Allied Health Professionals  ☐ Department for Child Protection  ☐ Early Learning/Preschool/Education  Referral must be via Leadership Team in consultation with Support Services e.g. Speech Pathology, Psychology or DECD Special Educator, Catholic Education / Association of Independent Schools SA Special Education Consultants/Advisors. Reports documenting this consultation must be provided\*\*  Documentation of this consultation process must be provided. If assessments have been conducted copies must be attached before referral can be considered | | |

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| **Please Confirm the following:** |
| ☐Yes ☐No Is Parent/Caregiver/Guardian aware of application?  ☐Yes ☐N/A Would Parent/Caregiver/Guardian like assistance to complete CDU Forms?  ☐Yes ☐ No Has the child had a Comprehensive Health & Development Assessment  ☐Yes ☐No ☐N/A Is there a Family Court Order in Place? Is Yes, a copy must be attached.  ☐Yes ☐No ☐Unsure Is the child registered with NDIS?  ☐Yes ☐No ☐Unsure If yes, is the child receiving services via the NDIS? |

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| **Does the child meet our criteria of 3 or more areas of developmental concern?** |
| **CDU CRITERIA:**  ☐ Fine motor problems (handwriting, cutting, manipulation and dexterity)  ☐ Gross motor problems (locomotor, ball skills, coordination, climbing, motor planning)  ☐ Speech and language problems (excluding stuttering)  ☐ Sensory processing issues (sensitivities or sensory seeking behaviours)  ☐ Socialisation problems (not relating to peers, poor play skills, poor non-verbal skills, conversation skills, reduced eye contact)  ☐ Behaviours as listed  ☐ Repetitive behaviours/play, need for routines/rituals, obsessive interests. Inflexibility, unusual posturing of the body/movement patterns, unusual use of language  ☐ Children >5 years – inattentive, hyperactive, impulsive behaviours, poor planning and organisation  ☐ Self care skills (dressing, feeding self, toileting - excluding constipation)  ☐ Learning Difficulties (reading, spelling, maths or all)  **FETAL ALCOHOL SPECTRUM DISORDER (FASD)**  Fetal Alcohol Spectrum Disorder (FASD) is a term used for a spectrum of conditions caused by prenatal alcohol exposure.  Referrals for Fetal Alcohol Spectrum Disorder require the FASD Referral Appendix completed with this CDU  Referral Form. This form can be obtained from our web page or contact our Unit to request the FASD Referral Appendix via Health.CDU@sa.gov.au  **CDU DOES NOT ACCEPT REFERRALS FOR:**  ☐ Residing outside of CDU catchment area (unless outside of accepted age range for catchment)  ☐ Single area of concern  ☐ Not on CDU referral form  ☐ Paediatric Management - Due to increased demand for assessments, the CDU does not have capacity to provide ongoing paediatric management. |

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| **Reason for referral to CDU?** |
| ☐ Comprehensive Developmental Assessment  ☐ Autism Spectrum Disorder  ☐ FASD  **Summary of reason for referral to CDU:**  Dear Doctor,  Thank you for seeing |

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| **Details of assessments conducted by education** | | | |
| **EDUCATION ASSESSMENTS** | **CONTACT** | **ASSESSMENT** | **DATE** |
| **Leadership Team** | q Yes | q Yes |  |
| **Speech Pathology** | q Yes | q Yes |  |
| **Psychology** | q Yes | q Yes |  |
| **Special Educator** | q Yes | q Yes |  |

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| **Details of previous assessments** |
| *E.g. Psychology, Speech Pathology, Physiotherapy, Occupational Therapy, Autism Diagnostic assessment*  *Please attach copies if you have* |

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| **Details of current services** | |
| **Professional** | **Name** |
| Paediatrician/ Medical Specialist |  |
| Speech Pathologist |  |
| Occupational Therapist |  |
| Physiotherapist |  |
| Psychologist |  |
| Audiologist |  |
| Optometrist |  |
| Other (please state) |  |

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| **Describe any difficulties the child is having in the following areas:** |
| Language understanding or use:  Fine motor skills, including handwriting:  Gross motor skills (e.g. balance, coordination):  Sensory processing/responses:  Self-help skills:  Social skills:  Making or keeping friends:  Behaviour:  Emotional Regulation:  Using or understanding gestures or body language:  Intense or unusual interests:  Coping with changes  Learning new skills/concepts:  School progress:  Attention and concentration:  General Health:  Sleep:  Diet:  Other: |

**Medical History:**

**Allergies:**

**Current Medications:**

**Social History:**

**Family History:**

**Observations:**

* Height =
* Weight =
* Percentile:

**Relevant Investigations:**

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| **WCH Office Use Only** | | | |
| **MRN #:** | | **Visit ID#:** | |
| **Clinic: CDU** | | **Pre-triaged:** | |
| **Appt Date:** |  | **Appt Time:** |  |
|  | | | |
| **WCH Clinician Use Only** | | | |
| **Triaged by:** |  | **Date Triaged:** |  |
| **Appointment type:** | q NEW | q REVIEW |  |
|  | q Face to Face | q Video | q Telephone |
| **Confirm Clinic:** |  | **Confirm Consultant:** |  |
| **Triage Category** | | | |
| **q Rapid Access** | **q P1** | **q P2** | **q P3** |