

REFERRAL FORM

Version: v1.2025 | Last Updated: January 2025

Healthy Koori Kids Clinic

Referral	MH UR	
Date	Number	

Healthy Koori Kids **can accept** a referral for a child or young person who:

- Identifies as Aboriginal and/or Torres Strait Islander and is aged between 0 and 17 years,
- Requires support for complex health and developmental needs where there is no existing team of health professionals in place,
- Lives in or attends school within the Monash Health catchment area (City of Casey, Cardinia, and Greater Dandenong). Referrals outside the Monash Health catchment will be considered on a caseby-case basis,
- Is not currently accessing or known to a Paediatrician,
- Is currently in Out-of-Home Care, including kinship care. Referrals for children not in Out-of-Home Care will be considered on a case-by-case basis.

Reason for referral
Please describe why this child needs a paediatrician assessment, and any other considerations.

Information of the Child

Surname:	Title:
First Given Name:	
Second Given Name: (if applicable)	
Preferred Name:	
Birth Date:	Gender:
Cultural Identity (e.g. Aboriginal/Torres Strait Islander)	



Court Orde	<u>;r </u>								
Is there a Legal Court Order in Place?			□ Yes				□ No		
Order Type:	☐ Temporary Assessme ☐ Care by Se	ent Order		Interim Accommoda Order Long-Term	1		Family Preservation Order Permanent Care	re \Box	Family Reunification Order Undertaking
	Order			Care Order		_	Order		<u> </u>
Describe th	he Orders Timefr	rame:							
Describe a	any Access Restr	riction:							
Primary Care	nrer and Legal of the click the adult who the click the adult who the click						Guardian ardian is the adult wh	'ho has le	egal parental responsibilities.
Title:			_		R	Role:			
Legal Surn	name:				T	Γitle:			
Legal First Name:						₋egal Surna	ıl ame:		
Ivamo.					Le		l First		
Residentia Address:	.l					Addre			
Contact Number:			_		N	Conta Numb	ber:		
SMS Notification	ns:	Yes		۷o	_	SMS Notifi	ications:	☐ Yes	s □ No
	nip to client (e.g. pa	arent, grandpare	nt, fo	oster carer)			tionship to client ((e.g. pare	ent, DFFH worker)
Email:			_		E	Email	l:		
Department	t of Family, Fai	airness and	Ho	using (Chil	ld Prc	ote <u>c</u>	etion)		
	Name				Ema			Te	elephone Contact
Does the c	client have a cultu	ural safety pla	an?	☐ Ye:	es		□ No		



Education			
Name of school or day car	·e:		
Name of best contact pers	on at the school:		
Mobile and email for conta	act:		
Student's current year level:			
Case Manager (e.g. VA	CCA, OzChild, Anglicare	e, etc.)	
Agency	Name	Email	Telephone Contact
General Practitioner Do	octor (GP)		
Doctor's Name	octor (Gr)	Medical Practice	
Postal Address:		Name:	
Suburb:			
State:		Posto	code:
Telephone Number:			
Medicare Card Number:		Reference Number on Card:	



Referee's Details
Organisation:
Legal Surname:
Legal First Name(s):
Email Address:
Postal Address:
Contact Number:
By sending this completed referral form. I certify that I have discussed this with the child's guardian and carer.

Date signed

Please submit this completed form to healthykoorikids@monashhealth.org, along with the following documents:

☐ 715 GP Health Assessment (most recent)
 ☐ Consent to Share Information (click this <u>link</u> for this form)
 ☐ Legal /Court Documentation

□ Cultural Care Plan

Signature of the referee

For more information, visit Healthy Koori Kids webpage by either using the QR code or by clicking the link below:



Monash Health

Aboriginal Health Paediatrics HEALTHY KOORI KIDS

