

**MONASH HEALTH
CHILD HEALTH REFERRAL TOOL**

Referral Email Address:
referrals.childandfamily@monashhealth.org

Phone: 8572 5631 (Option 3)

Reset Form

UR:
Patient Name:
DOB:
Sex:
Address:
Mobile:
Family Email:

REFERRER DETAILS:

Referrer Name:	Referral Date:
Address:	
Email Address:	Contact Number:

ELIGIBILITY:

Does the child have any formally diagnosed developmental condition? (e.g. Cerebral Palsy, Asperger's, Autism, ID, global developmental delay)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the child been referred to or are they receiving services from NDIS/Early Childhood Intervention? **Yes = not eligible for community C&F services. Advise of NDIS C&F service	<input type="checkbox"/> **Yes	<input type="checkbox"/> No
Has the child commenced primary school? **Yes = not eligible for Developmental Screen or Speech Therapy. Is eligible for other disciplines OT until 12 years, Physiotherapy, Podiatry, Dietetics until 18 years, Psychology & Counselling until 14 years	<input type="checkbox"/> **Yes	<input type="checkbox"/> No
If a parent is on a student visa, not eligible for our service	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If out of catchment, referral should be re-directed to the family's local community health service	<input type="checkbox"/> Yes	<input type="checkbox"/> No

PRIORITY

URGENT ROUTINE

Tick all relevant criteria:

- Homelessness or at risk of homelessness
- Current/present risk of family violence
- Refugee / Asylum Seeker
- Visa Status:
- Aboriginal and/or Torres Strait Islander
- Child Protection, Child FIRST, Out of Home Care
- Current Court Order?
- Copy of Court Order provided?
- Current medicare card?

INCOME LEVEL:

The Child & Family Program is part of Monash Health Community which provides services for children and families. Your annual combined household income will determine the cost of services you receive from our Program.

Family (1 Child)	Family (2 Child)	Family (3 Child)	Family (4 Child)
Less than \$66,009 Low Fee	Less than \$72,215 Low Fee	Less than \$78,421 Low Fee	Less than \$84,627 Low Fee
Between \$66,009 - \$118,546 Medium Fee	Between \$ 72,215 - \$124,752 Medium Fee	Between \$78,421 - \$130,958 Medium Fee	Between \$ 84,627 - \$137,164 Medium Fee
More than \$118,546 High Fee	More than \$124,752 High Fee	More than \$130,958 High Fee	More than \$137,164 High Fee

<input type="checkbox"/> Health Care Card (\$0 cost)	<input type="checkbox"/> Low income - \$10 per session	<input type="checkbox"/> Medium income - \$10 per session	<input type="checkbox"/> High income - \$100 per session
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CONSENT:

Are the parents / carers / other aware of the referral?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do they consent to the referral to Service?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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If no, reason?

FAMILY:

Primary Caregiver	Name:	Gender:	Occupation:
	Email:	Phone:	Relationship:
Other Caregiver	Name:	Gender:	Occupation:
	Email:	Phone:	Relationship:
Living Arrangements	Who lives in the house? (parents, grandparents, siblings)		
Siblings	No. of siblings: <input type="text"/>	Age of siblings: <input type="text"/>	
Language Spoken	Child: <input type="checkbox"/> English <input type="checkbox"/> Other Specify: <input type="text"/>	Parent: <input type="checkbox"/> English <input type="checkbox"/> Other Specify: <input type="text"/>	
Interpreter Required?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Language required: <input type="text"/>	

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MEDICAL:

MainArea of Concern:

Is the child becoming frustrated by their difficulties?

Yes No

If yes, provide details:

Medical History:

Prematurity: How many weeks?

Tube feeding (NGT/PEG):

Cardiac/respiratory/endocrinology history:

Other medical:

Family History / Social History:

Allergies: Yes No

Reaction: Severity:

Details:

Vision

Does the child have any vision difficulties? Yes No

If yes, please outline:

Hearing

Date of last hearing test Yes No

Results

Permanent hearing loss diagnosed? Yes No
Requiring hearing aid or cochlear implant?

If yes, eligible for NDIS

Grommets inserted? Yes No

Date inserted:

Other Services involved:

Please tick all services currently or previously involved with your child:

Maternal & Child Health

Paediatrician

None of the above

Day Care/Family Day Care

Medical Specialist (e.g., ENT):

Other: (specify)

Playgroups and/or support groups

Private Therapy (speech, OT, counselling etc.)

Other: (e.g. audiologist) please specify

Early Childhood Intervention services (NDIS/ECIS/ECEI)

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Development	Can your child...	YES	NO	Comments
Speech	Expressive Language difficulty	<input type="checkbox"/>	<input type="checkbox"/>	
	Receptive Language difficulty	<input type="checkbox"/>	<input type="checkbox"/>	
	Articulation/Speech Sound difficulty	<input type="checkbox"/>	<input type="checkbox"/>	
	Stuttering	<input type="checkbox"/>	<input type="checkbox"/>	
	Feeding difficulty	<input type="checkbox"/>	<input type="checkbox"/>	
	Social-Communication (including selective mutism)	<input type="checkbox"/>	<input type="checkbox"/>	
Occupational Therapy	Fine Motor	<input type="checkbox"/>	<input type="checkbox"/>	
	Cognition	<input type="checkbox"/>	<input type="checkbox"/>	
	Toileting	<input type="checkbox"/>	<input type="checkbox"/>	
	Self -care	<input type="checkbox"/>	<input type="checkbox"/>	
	Gross Motor	<input type="checkbox"/>	<input type="checkbox"/>	
Physiotherapy	Plagio	<input type="checkbox"/>	<input type="checkbox"/>	
	Talipes	<input type="checkbox"/>	<input type="checkbox"/>	
	Developmental milestones (not rolling or sitting on time)	<input type="checkbox"/>	<input type="checkbox"/>	
	Orthopaedic / Musculoskeletal Concern	<input type="checkbox"/>	<input type="checkbox"/>	
	Pain affecting Function (please specify where)	<input type="checkbox"/>	<input type="checkbox"/>	
	Pain not affecting function	<input type="checkbox"/>	<input type="checkbox"/>	
	No Pain	<input type="checkbox"/>	<input type="checkbox"/>	
Dietician	Feeding	<input type="checkbox"/>	<input type="checkbox"/>	
	Fussy Eating	<input type="checkbox"/>	<input type="checkbox"/>	
	Enteral Feeds	<input type="checkbox"/>	<input type="checkbox"/>	
	Nutrition issue (including allergies or Nutrient deficiencies)	<input type="checkbox"/>	<input type="checkbox"/>	
	Overweight	<input type="checkbox"/>	<input type="checkbox"/>	
	Other	<input type="checkbox"/>	<input type="checkbox"/>	
Podiatry	Skin and nail infection	<input type="checkbox"/>	<input type="checkbox"/>	
Counselling / Psychology	Anxiety and Depression	<input type="checkbox"/>	<input type="checkbox"/>	
	Behaviour / Cognition	<input type="checkbox"/>	<input type="checkbox"/>	
	Bereavement	<input type="checkbox"/>	<input type="checkbox"/>	
	Other	<input type="checkbox"/>	<input type="checkbox"/>	
Referrer Name:		Designation:		Date: