MONASH HEALTH
HEALTHY MOTHERS HEALTHY BABIES
Referral Email Address:
referrals.childandfamily@monashhealth.org
Phone: 8572 5631 (Option 3)

HMHB Office Enquiries: 8558 9000

UR: .....
Surname: .....
Given name: .....
DOB: ..... **Age:** .....
Address: .....
.....
Phone: .....

REFERRER DETAILS:			
Referrer Name:		**Referral Date:**	
Referrer Role:		**Referrer Organisation:**	
Email Address:		**Contact Number:**	

ESTIMATED DUE DATE	Gravida & Parity	Maternity Hospital	Midwifery Clinic/Day

CONSENT:	
Has the client provided consent for the referral?	☐ Yes - Verbal Consent ☐ Yes - ClientSignature: _____ *Pleaseobtain consentbeforesendinga referralthrough.*

CLIENT DEMOGRAPHICS:			
Country of Birth:		**Interpreter Required?**	☐ Yes ☐ No
Aboriginal and/or Torres Strait Islander:		**Preferred Language:**	
Gender Identity:		**Preferred Pronouns:**	
Refugee/Asylum Seeker Status:		**Date of Arrival in Australia:**	
VISA Status/Type:		**Medicare Eligibility:**	☐ Yes ☐ No

EMERGENCY CONTACT/NEXT OF KIN:			
Name:		**Relationship:**	
Address:		**Contact Number:**	
Consent provided to contact if required? ☐			

Father of Baby (Full Name)	Date of Birth	Address / Phone Number
Partner Name (if different to Father of Baby)	**Date of Birth**	**Address / Phone Number**

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DETAILS OF HOUSEHOLD MEMBERS LIVING WITH CLIENT:	
Name	Relationship to client

DETAILS OF CLIENT'S OTHER CHILDREN (IF APPLICABLE):		
Child Name/D.O.B.	Address	Father of Child Name

PREGNANCY CARE AND SUPPORT REQUIRED *Provideasummaryof information foreachapplicable area*	
Accessto Antenatal Care:	
Birth Education and Planning:	
Early Parenting Education and Support:	
Health and Nutrition:	

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COMPLEX SOCIAL CHALLENGES WITH CLIENT, PARTNER AND FAMILY ***(Current and Historical)*** *Provideasummaryofinformation foreachapplicablearea*	
Family Violence:	
Alcohol/ Drugs/ Nicotine:	
Mental Health:	
Housing:	
Financial/ Income:	☐ Centrelink ☐ Employed ☐ No Known Income ☐ Other Financial Concerns *Details:*
Chronic/ Serious Illness and/or Disability: (E.g. ID, ABI, Spectrum disorders)	

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CURRENT STATUTORY INVOLVEMENT/ORDERS

Provideasummaryof information foreachapplicable area

DFFHChild Protection:	Current	☐ Yes ☐ No *Details:*
	Past	☐ Yes ☐ No *Details:*
	Unborn Report Made?	☐ Yes ☐ No *Details:*
		If Yes, is the client aware of the unborn notification? ☐ Yes ☐ No
	If there is DFFH involvement, please provide Child Protection Practitioner details:	
Legal Orders:	*Including IVOs, Department of Justice Orders, Child Protection, etc.*	

OTHER CONCERNS:

LIST OTHER SERVICES CURRENTLY WORKING WITH THE FAMILY:

GP, Housing service, MentalHealth, Alcohol& Drugs, etc.

Service Name	ContactName/Role	Contact Details *(Phone/Email)*

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