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 - Client Signature: ____________________ *Please obtain consent before sending a referral through.*

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 *Provide a summary of information for each applicable area*	
Access to 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)*** *Provide a summary of information for each applicable area*	
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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....

Phone: ....

<table>
<tr><th colspan="3">CURRENT STATUTORY INVOLVEMENT/ORDERS
Provide a summary of information for each applicable area</th></tr>
<tr><td rowspan="4">DFFH Child Protection:</td><td>Current</td><td>☐ Yes ☐ No

Details:</td></tr>
<tr><td>Past</td><td>☐ Yes ☐ No

Details:</td></tr>
<tr><td>Unborn Report Made?</td><td>☐ Yes ☐ No

Details:

If Yes, is the client aware of the unborn notification? ☐ Yes ☐ No</td></tr>
<tr><td colspan="2">If there is DFFH involvement, please provide Child Protection Practitioner details:</td></tr>
<tr><td>Legal Orders:</td><td colspan="2">Including IVOs, Department of Justice Orders, Child Protection, etc.</td></tr>
</table>

OTHER CONCERNS:

<table>
<tr><th colspan="3">LIST OTHER SERVICES CURRENTLY WORKING WITH THE FAMILY:
GP, Housing service, Mental Health, Alcohol & Drugs, etc.</th></tr>
<tr><td>Service Name</td><td>Contact Name/Role</td><td>Contact Details (Phone/Email)</td></tr>
<tr><td></td><td></td><td></td></tr>
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