



Children's Health Queensland  
Hospital and Health Service

## Specialist Referral

Medical Objects ID **RQ402900084**

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth:

### FAX REFERRAL TO 1300 407 281

**PATIENT DETAILS** [ Referral of new patients are accepted before their 16th birthday ]

Surname:

Given names:

Date of birth:

Age:

UR:

1. Sex recorded at birth: ☐ Male ☐ Female ☐ Please specify:

2. Gender: ☐ Boy / male ☐ Girl / female ☐ Non binary person ☐ Different term - specify:

Aboriginal or Torres Strait Islander origin: ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither

Medicare eligible: ☐ No ☐ Yes ▶ Card number: Card reference: Expiry: /

Address:

Suburb:

Postcode:

Ph (H):

Mobile:

Parent/Guardian/Agency name:

Relationship to patient:

Parent/Guardian/Agency contact details:

Interpreter required? ☐ No ☐ Yes ▶ preferred language:

Is child in out of home care? ☐ No ☐ Yes ▶ Child Safety Service Centre:

Are there any custody or guardianship issues? ☐ Yes ☐ No

Facility referred from:

Facility URN:

Length of referral and designation

☐ SMO/VMO/Specialist (3 months) ☐ Registrar/Resident (12 months) **GPs** ▶ ☐ Indefinite ☐ 12 months ☐ Telehealth referral

Is the referral urgent? ☐ Yes ☐ No If yes, please explain why:

Refer to a Specialty by selecting a ☒ **Head of Clinic** or completing the specialty field below. Referrals are shared with other Specialists in the clinic to ensure patients are seen as quickly as possible.

**Please note: Referrals to Genetic Health Queensland or Children's Oral Health are to be made to the Metro North Hospital and Health service**

#### Burns

☐ Prof Roy Kimble  
[ Fax: 3068 4329 ]

#### Cardiac Surgery

☐ Dr Prem Venugopal  
[ Fax: 3068 4329 ]

#### Cardiology

☐ Dr Timothy Colen  
[ Fax: 3068 4329 ]

#### Child Development

☐ Dr Helen Heussler

#### Child Health Service

#### Childhood Hearing Clinics

☐ Dr Helen Heussler

#### Child Protection & Forensic Medical Services

☐ Dr Jan Connors

#### Cleft & Cranio-facial

☐ Dr Stuart Bade

#### Dermatology

☐ Dr Tania Zappala

#### Endocrinology/Diabetes

☐ Dr Tony Huynh

#### ENT/Otolaryngology

☐ Dr Nicola Slee

#### Immunology & Allergy

☐ Dr Jane Peake

#### Fracture Clinic

☐ Dr David Bade  
[ Fax: 3068 4329 ]

#### Gait/Motion Analysis

☐ Dr John Walsh  
*Specialist only*

#### Gastroenterology & Hepatology

☐ Dr Nikhil Thapar

#### Gender Clinic

☐ Dr Brian Ross

#### General Paediatrics

☐ Dr David Levitt

#### Haematology

☐ Dr Jeremy Robertson  
[ Fax: 3068 4329 ]

#### Immunisation

☐ Dr Sophie Wen

#### Infectious Diseases & Immunisation Specialist Service

☐ Dr Julia Clark

#### Metabolic Medicine

Director - Anita Inwood

☐ Dr Coman / Lipke / Bursle

#### Nephrology

☐ Dr Peter Trnka

#### Neurology

☐ Dr Sophie Calvert

#### Neurosurgery

☐ Dr Robert Campbell  
[ Fax: 3068 4329 ]

#### Obesity

☐ Dr Anne Kynaston  
*QCH catchment only*

#### Oncology

☐ Dr Wayne Nicholls  
*For all Oncology referrals phone  
QCH on 3068 1111 - request to  
speak with the Oncologist on call*

#### Ophthalmology

☐ Dr Shuan Dai

#### Oral & Maxillofacial Surgery

☐ Dr Ben Erzetec

#### Orthopaedic Surgery

☐ Dr David Bade

#### Paediatric Surgery & Urology

☐ Prof Roy Kimble

#### Paediatric & Adolescent Gynaecology

☐ Prof Rebecca Kimble

#### Pain Clinic

☐ Dr Mark Alcock

#### Palliative Care

☐ Dr Anthony Herbert

#### Plastic & Reconstructive Surgery

☐ Dr Yun Phua

#### Rehabilitation/ Cerebral Palsy Health

☐ Dr Priya Edwards

#### Respiratory/Sleep Medicine

☐ Prof Alan Isles

#### Rheumatology

☐ Dr Ben Whitehead

#### Sleep Clinic

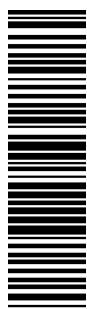
☐ Dr David Kilner

#### Vascular Malformations

☐ Prof Roy Kimble

Specialty:

DO NOT WRITE IN THIS BINDING MARGIN



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Date of Birth:

Patient name:

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**REASON FOR REFERRAL** (problem to be addressed)

**Background – history of presenting complaint & clinical question:** (comment on duration, severity, and treatment to date)

**Past medical history:**

**Current medications:**

**Allergies:**

**Immunisation status:**

**Social history and/or psychosocial risk factor/s:** (comment on home visit safety)

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Relevant family history:

### DEVELOPMENTAL ASSESSMENT [ for referrals to Child Development Service ]

**Thinking and Learning (Attention, learning new things, planning and problem solving, engagement at school/childcare)**

☐ No concerns ☐ Concerns – details:

**Communication (understanding, expressing self, clarity of speech)**

☐ No concerns ☐ Concerns – details:

**Social Skills and Play (Interaction and play with peers, underlying play skills and interests)**

☐ No concerns ☐ Concerns – details:

**Movement Skills (gross and fine motor skills, symmetry)**

☐ No concerns ☐ Concerns – details:

**Activities of Family Living and Independence (Mealtimes, dressing, toileting, sleep)**

☐ No concerns ☐ Concerns – details:

**Emotional Wellbeing Skills (Managing emotions + behaviour for age (e.g. escalation, withdrawal, length of time))**

☐ No concerns ☐ Concerns – details:

**Supporting documentation (please select and attach):**

☐ Information from school/kindy/childcare ☐ Paediatrician or other specialist reports

☐ Allied Health reports

☐ Other (specify):

☐ Guidance Officer reports

### RELEVANT INVESTIGATIONS ► PLEASE ATTACH COPIES

**REFERRING DOCTOR** [ Please complete all sections legibly – incomplete referrals will be returned ]

DR surname	DR given name	Provider #	
Hospital	Unit	Department	
Phone	Fax	Pager	
Is anyone else involved in the care of this patient?	Date:	Time:	Signature:

DO NOT WRITE IN THIS BINDING MARGIN