



Children's Health Queensland
Hospital and Health Service

Ellen Barron Family Centre Referral

EBFC USE ONLY

Affix ieMR **PARENT/CARER** identification label here

DATE OF REFERRAL:

Have you discussed the referral and the information provided with the parent/carer? ☐ Yes ☐ No

REFERRING HEALTH PROFESSIONAL

Name	Designation
Organisation	
Postal Address	
Suburb	Postcode
Phone	Email

DETAILS OF PARENTS / CARERS

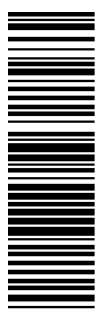
Full name	Full name
Previous surname	Previous surname
Date of birth	Date of birth
Birth country	Birth country
Address	Address
Suburb	Suburb
Postcode	Postcode
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
Relationship status	Relationship status
Are you Aboriginal or Torres Strait Islander? <input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Both <input type="checkbox"/> Neither	Are you Aboriginal or Torres Strait Islander? <input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Both <input type="checkbox"/> Neither
Cultural identity	Cultural identity
Home phone	Home phone
Mobile	Mobile
Email	Email
Interpreter required? <input type="checkbox"/> Yes <input type="checkbox"/> No	Interpreter required? <input type="checkbox"/> Yes <input type="checkbox"/> No
Preferred language	Preferred language

DETAILS OF CHILD / CHILDREN FOR ADMISSION

Full Name	Full Name
Date of birth	Date of birth
Age	Age
Birth country	Birth country
Address	Address
Suburb	Suburb
Postcode	Postcode
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
Are you Aboriginal or Torres Strait Islander? <input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Both <input type="checkbox"/> Neither	Are you Aboriginal or Torres Strait Islander? <input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Both <input type="checkbox"/> Neither
Sleep space <input type="checkbox"/> Cot <input type="checkbox"/> Toddler Bed <input type="checkbox"/> Other	Sleep space <input type="checkbox"/> Cot <input type="checkbox"/> Toddler Bed <input type="checkbox"/> Other

Please ensure all details are completed on all pages for prompt assessment of the referral.

NOTE: Please communicate to referred families that co-sleeping is not supported at Ellen Barron Family Centre.



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CHILD 1		CHILD 2	
Name		Name	
Birth weight	Current weight	Birth weight	Current weight
Is there a concern with the child's weight? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is there a concern with the child's weight? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Relevant medical or developmental history		Relevant medical or developmental history	
Any known allergies <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list		Any known allergies <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list	
REASON FOR REFERRAL (problem to be addressed, history of presenting concerns, strategies already attempted)			
<input type="checkbox"/> Sleep / settling (provide details of current settling / sleep associations, co-sleeping/bed sharing, contact napping practices, history of strategies already implemented and outcomes)			
<input type="checkbox"/> Feeding - breastfeeding/bottle feeding/solids (details of any concerns, history of strategies already implemented & outcomes)			
<input type="checkbox"/> Exclusive breastfeeding <input type="checkbox"/> Partial breastfeeding <input type="checkbox"/> Formula bottle feeding <input type="checkbox"/> Family diet			
PRIMARY PARENT / CARER INFORMATION			
Any known allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list			
Parent/carer medications / use of non-prescribed / illicit substances / medicinal cannabis (TGA approved vaporiser)			
Primary Parent/Carer's Mental Health Have there been any episodes of diagnosed emotional/mental illness in the past 2 years where the parent/carer sought medical advice and/or counselling? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide details:			



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Relevant issues regarding the parent/carer e.g. prejudicial childhood, substance abuse, personal/family trauma, social isolation, physical health/disability, learning/intellectual disability, domestic violence. If yes, provide details

Are there concerns regarding the parent/carer-child relationship?

☐ Yes ☐ No

If yes, provide details

Family supports / description of family social unit

Are there any current child protection concerns?

☐ Yes ☐ No

If yes, provide details

Are Department of Child Safety, Seniors and Disability Services (DCSSDS) involved? ☐ Yes ☐ No

If yes, provide name and contact details of Child Safety Service and Child Safety Officer

Child Protection Order / Intervention current: ☐ Yes ☐ No

Domestic Violence Order current: ☐ Yes ☐ No

Provide any additional relevant information that will be important for staff when reviewing this referral?

What other agents are currently providing services to the family?

- | | |
|--|--|
| <input type="checkbox"/> Child Health Service / day-stay program | <input type="checkbox"/> Psychiatrist |
| <input type="checkbox"/> General Practitioner | <input type="checkbox"/> 0-4 Child and Youth Mental Health Service |
| <input type="checkbox"/> Paediatrician | <input type="checkbox"/> Intensive Family Support (IFS) |
| <input type="checkbox"/> Paediatric Allied Health | <input type="checkbox"/> Family and Child Connect (FaCC) |
| <input type="checkbox"/> Social Worker / Psychologist | <input type="checkbox"/> Previous admission to Ellen Barron Family Centre |
| <input type="checkbox"/> Perinatal Mental Health / Perinatal Wellbeing team | <input type="checkbox"/> Previous admission to other residential parent centre |
| <input type="checkbox"/> Adult Mental Health | |
| <input type="checkbox"/> Other (e.g. Aboriginal & Torres Strait Islander Community Service, Benevolent Society) – specify: | |

Please ensure all details are completed on all pages for prompt assessment of the referral.

Name

Signature

Designation

Date

**External to Queensland Health please consider the Privacy Obligations for secure sending of Health Information.
Please FAX your completed form to 07 3068 3719**

Queensland Health staff can submit a referral by printing the completed form and either:

1. Emailing the completed form to EBFC-Referrals@health.qld.gov.au
2. Or printing and faxing to 07 3068 3719

EBFC Referral enquiries – PHONE 1300 408 213
More information: [Ellen Barron Family Centre | Children's Health Queensland](#)