Queensland Government

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 **Birth country**	**Date of birth** **Birth country**
Address **Suburb** **Postcode**	**Address** **Suburb** **Postcode**
Gender ☐ Male ☐ Female ☐ Other	**Gender** ☐ Male ☐ Female ☐ Other
Relationship status	**Relationship status**
Are you Aboriginal or Torres Strait Islander? ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither	**Are you Aboriginal or Torres Strait Islander?** ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither
Cultural identity	**Cultural identity**
Home phone **Mobile**	**Home phone** **Mobile**
Email	**Email**
Interpreter required? ☐ Yes ☐ No	**Interpreter required?** ☐ Yes ☐ No
Preferred language	**Preferred language**

DETAILS OF CHILD / CHILDREN FOR ADMISSION

Full Name	**Full Name**
Date of birth **Age**	**Date of birth** **Age**
Birth country	**Birth country**
Address **Suburb** **Postcode**	**Address** **Suburb** **Postcode**
Gender ☐ Male ☐ Female ☐ Other	**Gender** ☐ Male ☐ Female ☐ Other
Are you Aboriginal or Torres Strait Islander? ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither	**Are you Aboriginal or Torres Strait Islander?** ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither
Sleep space ☐ Cot ☐ Toddler Bed ☐ Other	**Sleep space** ☐ Cot ☐ Toddler Bed ☐ 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? ☐ Yes ☐ No	**Is there a concern with the child's weight?** ☐ Yes ☐ No
Relevant medical or developmental history	**Relevant medical or developmental history**
Any known allergies ☐ Yes ☐ No If yes, please list	**Any known allergies** ☐ Yes ☐ No If yes, please list

REASON FOR REFERRAL (problem to be addressed, history of presenting concerns, strategies already attempted)

☐ **Sleep / settling** (provide details of current settling / sleep associations, co-sleeping/bed sharing, contact napping practices, history of strategies already implemented and outcomes)

☐ **Feeding - breastfeeding/bottle feeding/solids** (details of any concerns, history of strategies already implemented & outcomes)
☐ Exclusive breastfeeding ☐ Partial breastfeeding ☐ Formula bottle feeding ☐ Family diet

PRIMARY PARENT / CARER INFORMATION

Any known allergies? ☐ Yes ☐ 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? ☐ Yes ☐ 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?

☐ Child Health Service / day-stay program
☐ General Practitioner
☐ Paediatrician
☐ Paediatric Allied Health
☐ Social Worker / Psychologist
☐ Perinatal Mental Health / Perinatal Wellbeing team
☐ Adult Mental Health
☐ Psychiatrist
☐ 0-4 Child and Youth Mental Health Service
☐ Intensive Family Support (IFS)
☐ Family and Child Connect (FaCC)
☐ Previous admission to Ellen Barron Family Centre
☐ Previous admission to other residential parent centre
☐ 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