

(Affix patient identification label here)

Referral to Head To Health Kids Queensland - Brisbane

Medical Objects ID RQ402900084

CHILD DETAILS - referrals accepted for children prior to their 12th birthday

Last name	First name	URN
Preferred name		
Date of birth & age	Gender (at birth)	Gender (current/if different)
Country of birth	Address	
School/Kindy or Daycare (if child enrolled)		
Does your child identify as <input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Both <input type="checkbox"/> Neither <input type="checkbox"/> South Sea Islander		
If Medicare eligible - Card no	Reference	Expiry

PARENT/CARER/GUARDIAN DETAILS

Last name	First name
Preferred name	Relationship to child
Country of birth	
Home address	
Contact details (email & mobile preferred)	
Language(s) spoken at home	Interpreter required? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are there any concerns relating to visiting the child at home (if necessary &/or appropriate)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes , please describe	

REFERRER DETAILS

Does the parent/carer consent to this referral? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name of person completing referral form		
Role/designation		
Organisation (if appropriate)	Provider number (if appropriate)	
Address		
Phone	Signature	Date
Email		

CURRENT CONCERNS

What are the challenges the child is experiencing, and what would be the goals of intervention from our service?

v5.00 - 12/2024



FUNCTION SCREENING QUESTIONS

Are there concerns with any of the following (PLEASE TICK 'YES' OR 'NO' FOR ALL AREAS)

Engagement in or attending school / daycare / Kindy (attention, behaviour etc)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Emotional wellbeing (managing own emotions appropriate for age, anxiety, withdrawal etc)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Communication (speaking, understanding, expressing self etc)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Social skills or play (playing with others, interest in playing, interaction with peers etc)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Thinking / learning / problem solving skills	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Physical wellbeing (energy / activity levels / moving their body)	<input type="checkbox"/> Yes	<input type="checkbox"/> No

SOCIAL DETERMINANT QUESTIONS

Does the child &/or family identify with any of the following challenges?

	Child	Family
Refugee / asylum seeker status	-----	<input type="checkbox"/> Yes <input type="checkbox"/> No
Housing instability	-----	<input type="checkbox"/> Yes <input type="checkbox"/> No
Financial stress	-----	<input type="checkbox"/> Yes <input type="checkbox"/> No
Domestic or family violence	-----	<input type="checkbox"/> Yes <input type="checkbox"/> No
Involvement of Child Safety	-----	<input type="checkbox"/> Yes <input type="checkbox"/> No
Disability or chronic illness	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drug or alcohol misuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
History of incarceration (prison)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Are there any services involved in supporting this child/family? How has this been helpful?

Availability for sessions – please indicate if you have a preference of day to be seen

<input type="checkbox"/> Monday <input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> Tuesday <input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> Wednesday <input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> Thursday <input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> Friday <input type="checkbox"/> AM <input type="checkbox"/> PM
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Please describe any relevant health history and medications for the child