Queensland Government

Children's Health Queensland Hospital and Health Service

Child Development Program Referral

(Affix patient identification label here)

Child Details

Last name: **First name:** **Date of birth:**

Address:

Sex: ☐ M ☐ F **Country of birth:** Australia ☐ Aboriginal or Torres Strait Islander

Alerts/allergies:

Family Details

Legal Guardian: ☐ Parent/s ☐ Other:

Name: **Relationship:**

Phone: **Mobile:**

Address:

Language spoken at home: **Interpreter required?** ☐ Yes ☐ No

Referral discussed with child's legal guardian? ☐ Yes ☐ No

Other relevant information: (family stressors / legal / court orders)

Referrer Details

Name: **Role:**

Organisation:

HHS / address: **Signature:**

Phone: **Date:**

Email:

GP's to complete the following – ☐ Referral for 12 months ***or*** ☐ Indefinite referral

Referral Information

Clinical concern or question (problem to be addressed, history of presenting concerns, suspected diagnosis, parental concerns)

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Name	DOB	UR No

Relevant developmental history (summary of developmental progression, consider speech and language, cognition/learning/attention, fine and gross motor, social emotional/play/behaviour, self-care)

Relevant medical/surgical history (general health, antenatal or perinatal factors such as drug/alcohol exposure, pre-term delivery or low birth weight)

Relevant social/family history (parental relationship issues, mental illness, substance abuse parental disability, family in crisis, Child Protection involvement, literacy/language considerations for parent/carer or other relevant information)

Recent investigations or assessments (medical and/or allied health)

☐ Hearing checked (please attach results) ☐ Vision checked (please attach results)

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Name	DOB	UR No

Other Key Contacts

Name of school/care provider:

Grade level: (if school age)

Other agencies/therapy services involved: (GP League, Disability Services, Child and Youth Mental Health, private allied health)

Supporting documentation (select and attach)

- ☐ Information from school/kindy/childcare
- ☐ Guidance Officer reports
- ☐ Allied Health reports
- ☐ Paediatrician or other specialist reports
- ☐ Other (specify):

Thanks for your referral. Please forward this referral to: Child Development Program Access Service

SUBMIT ***or*** fax: **(07) 3068 5126**

Please note: This is a central access point for all Child Development Services in Brisbane. Referrals will be managed by the CDP Access Team and families will be supported to access their local Child Development Service or alternative service providers.

For more information please contact the CDP Access Team on **1300 731 805** or **CDPAccessService@health.qld.gov.au**

CDP ACCESS TEAM USE ONLY

Date referral received:

☐ Accepted ☐ Not accepted ☐ Referral Outcome Form sent

Processed by (name):	**Signature:**
Designation:	

Notes:

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