



Children's Health Queensland  
Hospital and Health Service

(QCH USE ONLY – affix patient identification label here)

## Specialist Referral

Medical Objects ID RQ402900084

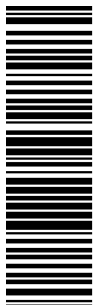
### FAX REFERRAL TO 1300 407 281

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

<b>Surname:</b>		<b>Given names:</b>	
<b>Sex:</b> <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> I	<b>Date of birth:</b>		<b>Age:</b>
<b>Aboriginal or Torres Strait Islander origin:</b> <input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Both <input type="checkbox"/> Neither			
<b>Medicare eligible:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes ▶ <b>Card number:</b>			
Card reference:		Expiry:	
<b>Address:</b>			
<b>Suburb:</b>	<b>Postcode:</b>	<b>Ph (H):</b>	<b>Mobile:</b>
<b>Parent/Guardian/Agency name:</b>		<b>Relationship to patient:</b>	
<b>Parent/Guardian/Agency contact details:</b>			
<b>Interpreter required?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes ▶ preferred language:			
<b>Is child in out of home care?</b> <input type="checkbox"/> Yes ▶ Child Safety Service Centre: _____ <input type="checkbox"/> No			
<b>Facility referred from:</b>		<b>Facility URN:</b>	
<b>Length of referral and designation</b>			
<input type="checkbox"/> SMO/VMO/Specialist (3 months) <input type="checkbox"/> Registrar/Resident (12 months) <b>GPs</b> ▶ <input type="checkbox"/> Indefinite <input type="checkbox"/> 12 months			
<input type="checkbox"/> Telehealth referral			
<b>Is the referral urgent?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			
If <b>yes</b> , please explain why:			
All children with <b>emergent</b> medical problems requiring immediate attention should be referred to a hospital Emergency Department for assessment. If you require assistance with this please contact the Children's Advice Transport Communication Hub (CATCH) on 3068 4525.			
Refer to a Specialty by selecting a <input checked="" type="checkbox"/> <b>Head of Clinic</b> from the list below. Referrals are shared with other Specialists in the clinic to ensure patients are seen as quickly as possible.			

DO NOT WRITE IN THIS BINDING MARGIN

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<b>Burns</b> Prof Roy Kimble [ Fax: 3068 4329 ] <b>Cardiac Surgery</b> Dr Nelson Alphonso [ Fax: 3068 4329 ] <b>Cardiology</b> Dr Robert Justo [ Fax: 3068 4329 ] <b>Child Development</b> Dr Helen Heussler <b>Child Protection &amp; Forensic Medical Services</b> Dr Jan Connors <b>Children's Oral Health Service</b> Dr Bruce Newman <b>Cleft &amp; Cranio-facial</b> Dr Stuart Bade <b>Dermatology</b> Dr Tania Zappala <b>Endocrinology/Diabetes</b> Dr Jerry Wales	<b>ENT/Otolaryngology</b> Dr Robert Black <b>Fracture Clinic</b> Dr David Bade [ Fax: 3068 4329 ] <b>Gastroenterology &amp; Hepatology</b> Dr Fariha Balouch <b>Gender Clinic</b> Dr Brian Ross <b>General Paediatrics</b> Dr David Levitt <b>Genetics</b> Dr Julie McGaughran <b>Haematology</b> Dr Simon Brown [ Fax: 3068 4329 ] <b>Immunisation</b> Dr Sophie Wen <b>Immunology &amp; Allergy</b> Dr Jane Peake <b>Infectious Diseases &amp; Immunisation Specialist Service</b> Dr Julia Clark	<b>Metabolic Medicine</b> Dr Jim McGill <b>Nephrology</b> Dr Peter Trnka <b>Neurology</b> Dr Sophie Calvert <b>Neurosurgery</b> Dr Robert Campbell [ Fax: 3068 4329 ] <b>Obesity</b> Dr Anne Kynaston <b>Oncology</b> Dr Wayne Nicholls <i>For all Oncology referrals phone QCH on 3068 1111 – request to speak with the Oncologist on call</i> <b>Ophthalmology</b> Dr Shuan Dai <b>Oral &amp; Maxillofacial Surgery</b> Dr Ben Erzetich <b>Orthopaedic Surgery</b> Dr David Bade	<b>Paediatric Surgery &amp; Urology</b> Prof Roy Kimble <b>Paediatric &amp; Adolescent Gynaecology</b> Prof Rebecca Kimble <b>Pain Clinic</b> Dr Mark Alcock <b>Palliative Care</b> Dr Anthony Herbert <b>Plastic &amp; Reconstructive Surgery</b> Dr Stuart Bade <b>Rehabilitation/ Cerebral Palsy Health</b> Dr Priya Edwards <b>Respiratory/Sleep Medicine</b> Prof Alan Isles <b>Rheumatology</b> Dr Ben Whitehead <b>Sleep Clinic</b> Dr David Kilner <b>Vascular Malformations</b> Prof Roy Kimble
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## Specialist Referral

Medical Objects ID **RQ402900084**

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Patient name:

Date of birth:

**REASON FOR REFERRAL** (problem to be addressed; history of presenting concerns)

Past medical history and outcome of physical examination:

Current medications:

Allergies:

Immunisation status:

Social history and/or psychosocial risk factor/s:

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## Specialist Referral

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Patient name:

Date of birth:

Relevant family history:

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

#### Thinking and Learning

No concerns  Concerns – details:

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

No concerns  Concerns – details:

#### Movement Skills (gross and fine motor skills)

No concerns  Concerns – details:

#### Social / Play / ADLs

No concerns  Concerns – details:

#### Emotional Wellbeing Skills

No concerns  Concerns – details:

#### Concentration / Executive Function Skill

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		DR position		Provider #	
Hospital or practice name			Phone		Fax		Pager
Unit or practice address					Department or practice suburb		
Is anyone else involved in the care of this patient?			Signature:		Date:		Time:

#### PATIENT'S USUAL GP [ if different from referrer ]

DR surname		Phone		Mobile		
Practice address				State		Postcode

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