After completing both sides of this form, please send to Centralised Intake
Fax: 02 4734 4401
Phone 02 4734 4400
Email: tfcc.intake@swahs.health.nsw.gov.au

OFFICE USE ONLY – PARENT MRN: ……………………………………… CHILD MRN: ………………………………………
INTAKE REF NO: ………………… DATE RECEIVED: ……………………
DATE OF PAI: ………. / ………. / …….. TIME: …………………
DATE OF ADMISSION: ……. / ………. / ………. TIME: ……………………
ADMISSION CONFIRMED DATE: SIGNATURE:
DATE OF D/S or OR APPT: …….. / ………. / ………. TIME: ……………………
Any contact with Infectious Illnesses in last 72 hours: ☐ Yes ☐ No

HEALTH PROFESSIONAL REFERRAL FORM TMR37

02/2010

REFERRAL SOURCE INFORMATION

Date of referral:	
Name:	
Position:	
Referral Agent's Organisation & Address:	
Phone:	Fax:
Email:	
GP Name:	Phone:
GP Address:	

INTERPRETER REQUIRED

☐ Yes ☐ No Language: ………
Language Spoken at Home:

Please indicate type of SECONDARY SERVICES UTILISED

☐FCC/Day Stay Name:
☐Paediatrician Name:
☐C&FHN Secondary Specialist Name:
☐Other Name:

CHILD INFORMATION (Please note – each child requires a separate referral form)

Surname:	
Given Name:	
Middle Name(s):	
Sex: ☐ Male	☐ Female
Date of Birth:	
Country of Birth:	

PARENT INFORMATION

Surname:	
Given Name(s):	
Street Address	
Suburb:	Postcode:
Phone (H):	(W):
Mobile:	
Email:	
Date of Birth:	Country of Birth:
Partner's Name:	Mobile:

PLEASE TICK PREFERRED SERVICE:

☐ Canterbury ☎(02) 9787 0827 **☐ Nepean ☎ (02) 4734 2124** **☐ Willoughby ☎ (02) 8962 8300** **☐ Wollstonecraft ☎ (02) 9432 4000**

Canterbury	Nepean	Willoughby	Wollstonecraft
[ ] Residential	[ ] Residential	[ ] Residential	[ ] Day Stay
[ ] Day Stay	[ ] Day Stay		[ ] Outreach
[ ] Outreach			

Please advise clients:
Day Stay/Outreach clients will be contacted by the Centre
Residential clients are to contact the Centre referred to after 3 working days to book a pre-admission interview

Tresillian use only: ☐ URGENT (within 7 days) ☐ HIGH PRIORITY ☐ ROUTINE
Comments:

Baby's Surname:	**First and Second Name(s):**

INFORMATION FROM REFERRING AGENT

Current Problem ____

____

____

Settling Issues ____

____

____

Feeding Issues ____

☐ Breast ☐ Solids ☐ Formula ____

Name of Formula: _____________ ____

Relevant Medical Conditions and Management/ Medication:	______________________ ______________________ ______________________
Mental Health Issues and Management EPDS Date: .... / .... / .... Score: Q10: Psychosocial screening attended ☐ Yes, please attach ☐ No	______________________ ______________________ ______________________ ______________________
Social Issues and Support	______________________ ______________________
Community Services involvement: ☐ Yes ☐ No **Brighter Futures:** ☐ Yes ☐ No Case Manager: Phone No: Child at Risk Issues: ☐ Yes ☐ No Outcome of risk issues?	______________________ ______________________ ______________________ ______________________ ______________________
Domestic Violence Screening **Attended**: ☐ Yes ☐ No Outcome of DV issues?	______________________ ______________________ ______________________
Other Agencies involved:	______________________ ______________________
Referral agent signature:	______________________

Do you want Centralised Intake to contact you to further discuss this referral? ☐ Yes ☐ No

If Yes, preferred availability: Day: …………………………….. Time: ……………………………

Please attach any relevant information eg Mental Health Assessments, Paediatric Reports, OT/Speech Therapy Assessment etc