Child and Adolescent Health Service
Perth Children's Hospital

# KOORLINY MOORT SERVICE

ABORIGINAL AMBULATORY CARE COORDINATION
Tel: 08 6456 0362 Fax: 08 6456 2030
Email: PCH.koorlinymoort@health.wa.gov.au

## PATIENT REFERRAL FORM

Med Rec. No: ..........................................................
Surname: ..........................................................
Forename: ..........................................................
Gender: ...................... D.O.B. ................................

AFFIX LABEL HERE

**Please send to: PCH Referrals Office**
**Email: pch.referrals@health.wa.gov.au**
**Facsimile: 6456 0097**

Has parent / carer confirmed child's Aboriginality?

Aboriginal not TSI ☐ Aboriginal and TSI ☐ TSI not Aboriginal ☐

Language Group:

Referrer:

Referring Organisation:

PCH Consultant: (*if applicable*)

Treating Specialties:(*if applicable*)

General Practitioner:

Name:

Address:

Telephone: Fax:

Medicare No. ________________________________ Expiry Date ____________________

CPFS involved? Yes ☐ No ☐ Office: Contact:

**Contact Details**

1) Residential Address:

Postal Address (*if applicable*):

Email Address

Would family consider Telehealth? Yes ☐ No ☐ Comments: ______________________________

2) Primary Contact

Name: Relationship: Phone:

3) Second Contact

Name: Relationship: Phone:

4) School Details (*if applicable*):

School attendance history:

Relevant Social History:

What are the issues or barriers affecting attendance?

| **Allergies** (drugs / food / environment) **& REACTION** | |
|---|---|
| Drug (or other) | Reaction & date if known |
| | |
| | |
| | |
| | |
| | |

**Immunisations Status** (*check AIR*): Up to date?

Yes ☐ No ☐ Nil immunisations ☐

Catch up schedule arranged? Yes ☐ No ☐

DO NOT WRITE IN BINDING MARGIN

HCHPCFMR3119

PC623
06/20

**PATIENT REFERRAL FORM**

**MR 311.90**



PC623 HCHPCFMR3119.indd 1 9/6/20 1:15 pm

| Child and Adolescent Health Service<br>Perth Children's Hospital<br>**KOORLINY MOORT SERVICE**<br>ABORIGINAL AMBULATORY CARE COORDINATION<br>Tel: 08 6456 0362 Fax: 08 6456 2030<br>Email: PCH.koorlinymoort@health.wa.gov.au<br>**PATIENT REFERRAL FORM** | Med Rec. No: ..........................................................<br>Surname: ................................................................<br>Forename: ..............................................................<br>Gender: ...................... D.O.B. ................................<br>AFFIX LABEL HERE |
|---|---|

**REASON FOR REFERRAL**

**– Care Coordination (Nurse Led) Past Medical Hx (Bloods, X-Rays, Regular Medication, Other)**

**Metro** ☐ **Kimberley** ☐ **Rural WA** ☐

*Care coordination (nurse led) for children with complex medical and neurodevelopmental needs requiring multiple appointments; children who have been difficult to contact; children who require review closer to home and country.*

**- Paediatric clinic for medical / neurodevelopmental appointment** ☐

*For children who require a paediatrician review closer to home*

***For neurodevelopmental issues also refer to CDS:***

Date referral made to Child Development Service (CDS) ____________________

Ages & Stages Questionnaire (ASQ) completed and attached Yes ☐ No ☐
*(if not please complete and bring to appointment)*

Any other supporting documents Yes ☐ No ☐

DO NOT WRITE IN BINDING MARGIN

**What outcome are you expecting from referral?**

**What attempts have been made to make contact with family?**

| **PCH Allied Health Involved:** | Yes ☐ No ☐ | |
|---|---|---|
| 1) Discipline: | Name: | Contact: |
| 2) Discipline: | Name: | Contact: |
| | | |
| **Community Services Involved:** | Yes ☐ No ☐ | |
| 1) Organisation: | Name: | Contact: |
| 2) Organisation: | Name: | Contact: |
| Social work involved? Yes ☐ No ☐ | Contact: | |

**Has consent for referral to Koorliny Moort service been obtained from parent / carer? Yes** ☐ **No** ☐

If no, please state your reason or concern: ______________________________________________

______________________________________________

______________________________________________

If inpatient, has referral been discussed with Koorliny Moort Fellow / Registrar prior to discharge? Yes ☐ No ☐

Date ____________________ Signature of Referrer ______________________________



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