Government of **Western Australia**
**Child and Adolescent Health Service**

CHILD AND ADOLESCENT COMMUNITY HEALTH

# REFERRAL TO REFUGEE HEALTH

Referring clinician name and designaton:

Service site:

Phone:

Email:

Preferred method of contact:

Family name:

Given name:

UMRN: DOB:

Sex (as on birth certificate):

☐ Male ☐ Female ☐ Indeterminate ☐ Unknown

Pronouns (optional):

☐ He/him/his ☐ She/her/his ☐ They/them/their

☐ Other:

Address:

Medicare no:

Email form to: **CACH.RefugeeHealthReferrals@health.wa.gov.au**

**I**

Country of origin:

Parent/caregiver name:

IDENTIFY

Date of arrival in Australia:

Visa type:

Interpreter required: ☐ Yes ☐ No

Language and dialect:

Parent/caregiver telephone:

Parent/caregiver email:

Alternative contact:

Relationship: Phone:

Consent for referral:

☐ Parent/guardian ☐ Mature minor

**S**

SITUATION

**Reason for handover/referral**

Do not write in margin

CHS080 REFERRAL TO REFUGEE HEALTH

Child's family name: ..... Given name: ..... DOB: .....

**O** OBSERVATIONS

**Relevant assessments/observations**

**B** BACKGROUND

**Relevant information** (health and development, siblings, family/social situation, support services, mobility and communication considerations)

**Precautions/alerst:** ☐ Allergy ☐ Adverse drug reaction

Details:

**A** AGREED PLAN

**Care plan** (What needs to happen, timeframe, interventions requested, roles and responsibilities)

Other information attached? ☐ Yes ☐ No

Total number of pages attached excluding this form:

**R** READ BACK

**Handover/referral method** ☐ Phone ☐ Face-to-face ☐ Email ☐ Mail

| **Lead** clinician signature (or HE number): | Date: | Time: |
|---|---|---|
| | | |

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