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

Confidential – Patient Information

COMMUNITY HEALTH

NEONATAL SPECIAL REFERRAL TO CHILD HEALTH SERVICES

The original copy of this form needs to be filed permanently in the correspondence section of the medical record. Complete ALL sections.

Family name*: .....

Given name*: .....

UMRN: ..... DOB*: .....

Sex* (as on birth certificate):

☐ Male ☐ Female ☐ Indeterminate ☐ Unknown

Address: .....

Note: fields with * are mandatory.

Demographic details

Mother's family name*: _____ Mother's given name*: _____

Mother's phone*: _____ Mother's medical record: _____

Main language: _____ Interpreter required: ☐ Yes ☐ No

Permanent residential address: _____

Secondary contact name: _____ Secondary contact phone: _____

Baby details

Birth site*: _____ Gestation at birth: _____ Birth weight: _____

Transferred to: _____ Transferred date: _____ Method of feeding: _____

Discharge date: _____ Age at discharge: _____ Discharge weight: _____

Discharging hospital/ Unit: _____ Expected discharge date: _____

Discharge address:

☐ Same as permanent address

☐ Temporary residential address (provide details): _____

Identified Risk Factors/Reason for Referral

Parent factors

☐ Alcohol and/or drug use
☐ Indication of foster care or adoption
☐ Family instability, conflict, or violence
☐ Unsupported teenage parent
☐ Homelessness
☐ Anxiety, depression, or other mental illness
☐ Child Protection involvement
☐ Rejection of baby or poor attachment
☐ Lack of support at home and/or social isolation
☐ Intellectual or physical disability
☐ Maternal morbidity e.g. post-partum haemorrhage greater than 1L, birth complications (e.g. shoulder dystocia, breech, perineal tear 3rd or 4th degree) or hospital readmission.

Infant factors

☐ Low birth weight
☐ Physical issues post birth, trauma, disability
☐ Weight loss >10% of birth weight
☐ Difficulties in feeding
☐ Indeterminate sex
☐ Hospital readmission for neonate
☐ Multiple birth
☐ Prematurity
☐ Stillbirth or neonatal death
☐ Transfer to Special Care Nursery or NICU
☐ Other infant morbidity

Home and community environment factors impacting child health

☐ Exposure to smoking
☐ Overcrowded housing
☐ Poor access to healthy food
☐ Remote community
☐ Other _____
☐ Housing - unsafe
☐ Poor sanitation and/or lack of fresh water
☐ Poor access to transport

Do not write in margin

CHS501 NEONATAL SPECIAL REFERRAL TO CHILD HEALTH SERVICES

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

Other teams/agencies involved (e.g. Department of Communities, Social Work, Paed, Mother Baby Unit, home visiting services, other specialists, other support services)

Team: _____ Contact name: _____ Contact no: _____

Team: _____ Contact name: _____ Contact no: _____

Team: _____ Contact name: _____ Contact no: _____

Team: _____ Contact name: _____ Contact no: _____

Summary of care (include discharge medication, future follow up, feeding plan, etc)

Further screening required:

☐ Newborn hearing ☐ Newborn blood spot screening ☐ Syphilis

☐ Other _____

Verbal handover required?* ☐ Yes ☐ No If yes, provide contact phone number: _____

Referrer details

Name*: _____ Signature/HE#: _____ Designation: _____

Site name*: _____ Ward phone*: _____

Generic email*: _____ Referred date*: _____

If client resides in **Perth Metropolitan area**: BirthNotificationsCDIS.CACH@health.wa.gov.au
If client resides in **WA Rural and remote area**: AreaOfficePopulationHealth.WACHS@health.wa.gov.au

To maintain patient confidentiality, it is recommended that the forms are emailed as per the individual service provider's transmission of client health information guidance documents.

Do not write in margin