



Children's Health Queensland
Hospital and Health Service

Ellen Barron Family Centre Referral

Medical Objects ID: RQ402900084

EBFC USE ONLY

Affix ieMR PARENT/CARER identification label here

DATE OF REFERRAL:

Have you discussed the referral and the information provided with the parent/carer? Yes No

REFERRING HEALTH PROFESSIONAL

Name	Designation
Organisation	
Postal Address	
Suburb	Postcode
Phone	Email

DETAILS OF PARENTS / CARERS

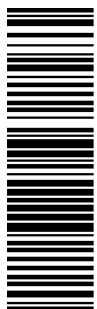
Full name	Full name
Previous surname	Previous surname
Date of birth	Date of birth
Birth country	Birth country
Address	Address
Suburb	Suburb
Postcode	Postcode
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
Relationship status	Relationship status
Are you Aboriginal or Torres Strait Islander? <input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Both <input type="checkbox"/> Neither	Are you Aboriginal or Torres Strait Islander? <input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Both <input type="checkbox"/> Neither
Cultural identity	Cultural identity
Home phone	Home phone
Mobile	Mobile
Email	Email
Interpreter required? <input type="checkbox"/> Yes <input type="checkbox"/> No	Interpreter required? <input type="checkbox"/> Yes <input type="checkbox"/> No
Preferred language	Preferred language

DETAILS OF CHILD / CHILDREN FOR ADMISSION

Full Name	Full Name
Date of birth	Date of birth
Age	Age
Birth country	Birth country
Address	Address
Suburb	Suburb
Postcode	Postcode
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
Are you Aboriginal or Torres Strait Islander? <input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Both <input type="checkbox"/> Neither	Are you Aboriginal or Torres Strait Islander? <input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Both <input type="checkbox"/> Neither
Sleep space <input type="checkbox"/> Cot <input type="checkbox"/> Toddler Bed <input type="checkbox"/> Other	Sleep space <input type="checkbox"/> Cot <input type="checkbox"/> Toddler Bed <input type="checkbox"/> Other

Please ensure all details are completed on all pages for prompt assessment of the referral.

NOTE: Please communicate to referred families that co-sleeping is not supported at Ellen Barron Family Centre.



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CHILD 1		CHILD 2	
Name		Name	
Birth weight	Current weight	Birth weight	Current weight
Is there a concern with the child's weight? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is there a concern with the child's weight? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Past medical/surgical or developmental history		Past medical/surgical or developmental history	
Any known allergies <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list		Any known allergies <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list	

REASON FOR REFERRAL (problem to be addressed, history of presenting concerns, strategies already attempted)

Sleep / settling (provide details of current settling / sleep associations, co-sleeping/bed sharing, contact napping practices, history of strategies already implemented and outcomes)

Feeding - breastfeeding/bottle feeding/solids (details of any concerns, history of strategies already implemented & outcomes)
 Exclusive breastfeeding Partial breastfeeding Formula bottle feeding Family diet

PRIMARY PARENT / CARER INFORMATION

Any known allergies? Yes No
If yes, please list

Parent/carer medications / use of non-prescribed / illicit substances / medicinal cannabis (TGA approved vaporiser)

Primary Parent/Carer's Mental Health

Have there been any episodes of diagnosed emotional/mental illness in the past 2 years where the parent/carer sought medical advice and/or counselling? Yes No
If yes, provide details:

Relevant issues regarding the parent/carer e.g. prejudicial childhood, substance abuse, personal/family trauma, social isolation, physical health/disability, learning/intellectual disability, domestic violence. If yes, provide details



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Are there concerns regarding the parent/carer-child relationship? Yes No

If yes, provide details

Family supports / description of family social unit

Are there any current child protection concerns? Yes No

If yes, provide details

Are Department of Child Safety, Seniors and Disability Services (DCSSDS) involved? Yes No

If yes, provide name and contact details of Child Safety Service and Child Safety Officer

Child Protection Order / Intervention current: Yes No

Domestic Violence Order current: Yes No

Provide any additional relevant information that will be important for staff when reviewing this referral?

What other agents are currently providing services to the family?

- | | |
|--|--|
| <input type="checkbox"/> Child Health Service / day-stay program | <input type="checkbox"/> Psychiatrist |
| <input type="checkbox"/> General Practitioner | <input type="checkbox"/> 0-4 Child and Youth Mental Health Service |
| <input type="checkbox"/> Paediatrician | <input type="checkbox"/> Intensive Family Support (IFS) |
| <input type="checkbox"/> Paediatric Allied Health | <input type="checkbox"/> Family and Child Connect (FaCC) |
| <input type="checkbox"/> Social Worker / Psychologist | <input type="checkbox"/> Previous admission to Ellen Barron Family Centre |
| <input type="checkbox"/> Perinatal Mental Health / Perinatal Wellbeing team | <input type="checkbox"/> Previous admission to other residential parent centre |
| <input type="checkbox"/> Adult Mental Health | |
| <input type="checkbox"/> Other (e.g. Aboriginal & Torres Strait Islander Community Service, Benevolent Society) – specify: | |

Please ensure all details are completed on all pages for prompt assessment of the referral.

Name

Signature

Designation

Date

**External to Queensland Health please consider the Privacy Obligations for secure sending of Health Information.
Please FAX your completed form to 07 3068 3719**

Queensland Health staff can submit a referral by printing the completed form and either:

1. Emailing the completed form to EBFC-Referrals@health.qld.gov.au
2. Or printing and faxing to 07 3068 3719