Government of **Western Australia**
Department of **Health**

OFFICE USE ONLY

Date received

UMRN

Intake site

Secondary site

Child Development Service Referral Form

PRINT VERSION

*** Indicates a mandatory field**

1 CLIENT DETAILS

*Child's surname:

*First name:

Please list any other names this child has been known by:

*Child's Gender:

Male Female

*Date of Birth:

Child's Current Age:

Mother's full name when she gave birth (for administration purposes):

Birth Hospital/Site:

*Address:

*Suburb:

*Postcode:

*Does this child/family have a Medicare Card? Yes No

Medicare Number, if known:

Is this child of Aboriginal descent? Unsure Yes No

If yes, which one?

Has this child attended a Child Development Service site before? Yes No

Is this child currently registered with the Disability Services Commission? Yes No

Is an interpreter required? Yes No

If yes, what language?

2 PARENT/GUARDIAN CONTACT DETAILS

***Primary contact person** *(Please tick one option)*

Mother/Guardian Father/Guardian

Other

*Title:

*Surname:

*First name:

*Address:

*Suburb: *Postcode:

Home Ph:

Mobile Ph:

Work Ph:

Email:

*Preferred method of contact:

Alternative contact person *(Please tick one option)*

Mother/Guardian Father/Guardian

Other

Title:

Surname:

First name:

Address:

Suburb: Postcode:

Home Ph:

Mobile Ph:

Work Ph:

Email:

Preferred method of contact:

3 REASON FOR REFERRAL (Please tick all that apply)

- ☐ Fine motor
- ☐ Gross motor
- ☐ Speech/language
- ☐ Family/relational
- ☐ Behaviour/emotion
- ☐ Feet/lower limbs/gait
- ☐ Head shape/position
- ☐ Hearing
- ☐ Functional skills (feeding, toileting, sleeping)
- ☐ Play skills
- ☐ Learning
- ☐ Sensory
- ☐ General
- ☐ Attention/concentration
- ☐ Other

*Please provide a detailed description of each identified developmental concern in the space provided below:

4 CLINICAL INFORMATION

Relevant Health History: (e.g. ENT history for speech & audiologyreferrals)

Additional Comments:

Date of last hearing test: Result:

Date of last vision test: Result:

Day care/school attending: Yr: Ph:

Teacher's name:

Has this child been referred to/seen by a school psychologist? Unsure ☐ Yes ☐ No ☐

Other agencies/professionals involved:

*Attached documents/reports: Yes ☐ No ☐

Please list attachments/reports:

5 REQUIRED INFORMATION – Parent/legal guardian consent

*(Insert name of parent/legal guardian)

gives consent for this child to be referred to the Child Development Service.

*Relationship to child: ☐ Mother/Guardian ☐ Father/Guardian ☐ Other (state relationship to the child below)

Has the parent/legal guardian consented for the CDS to contact the school/daycare? Unsure ☐ Yes ☐ No ☐

*Date of consent:

*Signature: or Verbal consent ☐

Please note: Referral cannot be considered without signed or verbal consent of the legal guardian

6 REQUIRED INFORMATION – Department for Child Protection and Family Support (CPFS)

*Is this child in the care of the CEO of the Department for Child Protection and Family Support (CPFS)? Yes ☐ No ☐

(Insert name of CPFS Authorised Officer)

gives consent for this child to be referred to the Child Development Service.

CPFS Office:

Email

*Date of consent:

*Signature: or Verbal consent ☐

Please note: Referral cannot be considered without signed consent

7 REQUIRED INFORMATION – Referrer information

***Referrer:** ☐ **Parent/legal guardian.** You are not required to complete the referrer information below.

☐ **Other.** Please complete the referrer information below.

Title: *Surname: *First Name

Occupation: Organisation/School:

*Address: *Suburb: *Postcode:

*Phone: Fax: *Email:

*Date of referral:

PLEASE RETURN COMPLETED REFERRAL BY ONE OF THE METHODS BELOW

Post: PO BOX 1095 West Perth 6872
Fax: 9426 7676
E-mail: childdevelopmentservice@health.wa.gov.au

Thank you for your referral. Please await contact from the Child Development Service.
For more information contact the Child Development Service on 1300 551 827.

Office use only

☐ Accept ☐ Single ☐ Multi ☐ Fast Track ☐ Urgent ☐ Decline RR: AA:

PAQ required ☐ Yes ☐ No Other enclosures/letters:

Client status/history:

Notes:

Data entry: Triage CNS: Date: