

**Referral Form** (to be sent with referral letter)

**Child Development Unit CHW**

Copies available through [www.chw.edu.au](http://www.chw.edu.au)

Intake contact: 98452395

Fax: 9845 2088

MRN: \_\_\_\_\_

Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Sex: \_\_\_\_\_

(Please affix CHW patient Label in this box if available)

**Completed** referral form will go through an Intake process to discuss and prioritise appropriate assessment and service required; no appointment will be given upon a phone referral.

Any enquiries regarding making a referral to CDU can be discussed with the Intake person.

**Patient Details**

Surname: \_\_\_\_\_ Given name: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Sex: Male  Female

Address: \_\_\_\_\_

P/Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_

Contact person: \_\_\_\_\_

Interpreter Required Language: \_\_\_\_\_ : Y  N

**Referring doctor details:** Name: \_\_\_\_\_

Provider number: \_\_\_\_\_

Mailing address: \_\_\_\_\_

Fax no: \_\_\_\_\_

Email: \_\_\_\_\_

Doctor's signature: \_\_\_\_\_

Date: \_\_\_\_\_

Practice stamp  
(if available)

**Presenting Problem:**

**Current developmental Skills:**

Expressive Language (eg. babble, single words, sentences, using gestures etc)

Receptive Language (eg. one stage or complex commands, understands gestures etc)

Play and Socialisation (eg. pretend play, initiates interaction, shows empathy)

Motor Skills (Gross and Fine motor)

Behaviour Concerns (eg. Tantrums, fixations or obsessions , anxiety)

Formal Hearing and Vision

Other Learning issues (eg. Inattention, , literacy)

**Background medical history:**


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**Medical Investigations to date** (eg. Blood tests – baseline and genetic DNA for Fragile X, CGH microarray, MRI/CT)

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**Relevant family history:**


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**Previous Assessments/Current interventions /Service involved:**

	Organisation involved	Report
Intellectual / Developmental assessment		Y <input type="checkbox"/> N <input type="checkbox"/>
Occupational Therapy		Y <input type="checkbox"/> N <input type="checkbox"/>
Speech Pathology		Y <input type="checkbox"/> N <input type="checkbox"/>
Audiology		Y <input type="checkbox"/> N <input type="checkbox"/>
School/Education/School Counsellor		Y <input type="checkbox"/> N <input type="checkbox"/>
Other (please specify)		Y <input type="checkbox"/> N <input type="checkbox"/>

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**Reason for referral / Clinical concerns**

Suspected Autism Spectrum  (Has item 135 been charged and referred for HCWA package Y  N  )

Speech / language impairment

Play / social interaction

Global delay

ADHD  Specific Learning Difficulties

Behaviour difficulties

Anxiety

Other (please specify):

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**Other information (e.g. psychosocial):**


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**CDU Intake discussion:**


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