



RCH Specialist Clinics Referral

Email all referrals to byfivewsm@rch.org.au

Telephone enquiries 0439 369 893 (Monday-Friday 9:00am-5:00pm)

<p>Please Note: A typed referral is required. Receipt of referral or rejection notifications will be via email within 10 working days</p> <p>The referrer may be contacted for more information before the referral is accepted. Once the referral is accepted, you will be sent advice on booking options, you must include your email address below.</p>	<p>Further information:</p> <p>Specialist Clinics: www.rch.org.au/specialist-clinics Pre-referral guidelines can be found here</p> <p>Primary Care Liaison: www.rch.org.au/kidsconnect</p> <p>Patient info fact sheets: www.rch.org.au/kidsinfo</p>
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Patient details (we require all fields of the patient details to be completed)

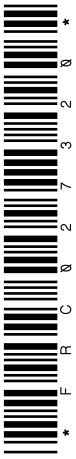
Patient surname		Given Name	
Date of Birth		RCH UR Number (if known)	
Gender			
Address		Postcode	
Parent/Carer Surname		Given Name	
Mobile Number		Landline number	
Medicare Number		Ref number	Expiry Date
Not Medicare Eligible			
Indigenous Status	<input type="radio"/> Aboriginal	<input type="radio"/> Torres Strait Islander	<input type="radio"/> Not indigenous
Interpreter required	<input type="radio"/> Yes	<input type="radio"/> No	Language

Clinical Details

Department: Wimmera Southern Mallee By Five Project
To Doctor: By Five Paediatrician
Is this a new referral or continuation of existing? <input type="radio"/> New <input type="radio"/> Existing
Reason for referral: <i>Include clinical findings, management to date, investigation results, relevant medical and social history, special needs, allergies and any current medications (attach as necessary)</i>

Referring details

Given Name	Surname	Referral duration <input type="radio"/> 3 months <input type="radio"/> 12 months <input type="radio"/> Indefinite <input type="radio"/> Other (specify) _____
Provider Number		
Practice Name		
Practice Address	Postcode	
Mobile Number	Landline number	
Referrer email address		



UR NUMBER

SURNAME

GIVEN NAME(S)

DATE OF BIRTH

AFFIX PATIENT LABEL HERE ↑

Consent – Centre CCH

Specialist Clinics Centre for Community Child Health

Re _____ UR: _____

Consent to release information

I _____ parent/guardian

of my child _____ give permission for
release of information to:

- family doctor, specialist
- community nurse
- allied health professionals - psychologist, speech pathologist, occupational therapist,
other
- teacher and/or appropriate school staff
- preschool teacher and/or other associated staff
- early childhood professional
- other, please specify _____

I give permission for the above to:

- complete questionnaires about my child's health, development, learning and behaviour
- discuss my child with Dr _____
- receive a copy of letters and/or reports written by Dr _____
about my child

Signed _____ Date _____