RCHSpecialistClinics Referral

Email all referrals to byfivewsm@rch.org.au
Telephone enquiries 0439 369 893 (Monday-Friday 9:00am-5.00pm)

Please Note: A typed referral is required. Receipt of referral or rejection notifications will be via email within 10 working days 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.	Further information: Specialist Clinics: www.rch.org.au/specialist-clinics Pre-referral guidelines can be found here Primary Care Liaison: www.rch.org.au/kidsconnect Patient info fact sheets: www.rch.org.au/kidsinfo

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	☐ Aboriginal	☐ Torres Strait Islander	☐ Not indigenous
Interpreter required	☐ Yes	☐ 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? ☐ New ☐ Existing
Reason for referral: *Include clinical findings, management to date, investigation results, relevant medical and social history, special needs, allergies and any current medications (attach as necessary)*

Referring details

Given Name Provider Number Practice Name Practice Address Mobile Number Referrer email address	Surname Postcode Landline number	Referral duration ☐ 3 months ☐ 12 months ☐ Indefinite ☐ Other (specifiy) _____

The Royal Children's Hospital Melbourne

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_____

Consent – Centre CCH MR92/C