Child Development Service	Insert Location	**FAX TO** Insert Number

Referral to: ☐ Audiology ☐ Nutrition/Dietetics ☐ Occupational Therapy ☐ Physiotherapy ☐ Speech Pathology ☐ Paediatrician ☐ Psychology ☐ Social Work ☐ Podiatry ☐ Early Intervention & Parenting Specialist

Please be advised that all referrals are triaged by clinical intake officer, and referrals may be redirected to most appropriate services.

Child's Details:	**Date** / /		
Surname:	First name/s:	Sex:	DOB: / /
Parent/Carer Details: Surname:	First name:	**Relationship to child:**	
Street: _____ Suburb: P/code	H ph:_____ W ph: _____ Mobile:		
Child's Medicare No:	Child's GP Record No:		
Ethnicity:	Primary Language:	Interpreter required: ☐ Yes ☐ No	

Reason for Referral: [Problem to be addressed, Presenting Condition, Suspected Diagnosis]

Significant Patient History: (Medical, Surgical, Social, Family)

Current Medications:

Complimentary Medications: (PI detail if applicable)

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Child's Name: DOB

Developmental History [Achievement of developmental milestones, speech, fine/gross motor skills, cognition, toileting issues (encopresis, nocturnal enuresis) feeding and growth (wt/ht/head circumference)]:

School History:	**Name of School/Centre**
☐ School - Year/Grade____ ☐ Child Care ☐ Kindy	

Extra Learning Support (if applicable): [Special school, Early Childhood Developmental Program (ECDP), Having learning support assistance, Guidance officer assessment, Accessing other supports at school/childcare, (inclusion support agency, speech pathology)]:

☐ Hearing checked (PI attach results) History of otitis media - pl specify:
☐ Vision checked (PI attach results)
☐ Other agencies/therapy services accessed - pl specify:

Allergies:

Supporting Documentation (Please Select and Attach):

- Information from School/Kindy/Childcare
- Guidance Officer Reports
- Cognitive Assessments
- Allied Health Report/s
- Paediatrician or other specialist report/s
- Other (Please specify):

Referring Dr Details

Name (PI print or stamp) **Provider No:**	**Practice Details** Practice Name _____ Street: _____ Suburb: _____ P/code _____
Dr Signature	Ph Fax

Individual Queensland Health CDS may choose to add a statement regarding guardian consent to this referral template.