



After completing both sides of this form,
 please send to Centralised Intake
 Fax: 02 4734 4401
 Phone 02 4734 4400
 Email: fcc.intake@swahs.health.nsw.gov.au

OFFICE USE ONLY – PARENT MRN:	
CHILD MRN:	
INTAKE REF NO:	DATE RECEIVED:
DATE OF PAI: / /	TIME:
DATE OF ADMISSION: / /	TIME:
ADMISSION CONFIRMED DATE:	SIGNATURE:
DATE OF D/S or OR APPT: / /	TIME:
Any contact with Infectious Illnesses in last 72 hours: <input type="checkbox"/> Yes <input type="checkbox"/> No	

REFERRAL SOURCE INFORMATION

Date of referral:	
Name:	
Position:	
Referral Agent's Organisation & Address:	
Postcode:	
Phone:	Fax:
Email:	

CHILD INFORMATION (Please note – each child requires a separate referral form)

Surname:	
Given Name:	
Middle Name(s):	
Sex:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth:	
Country of Birth:	

PARENT INFORMATION

Surname:	
Given Name(s):	
Street Address	
Suburb:	Postcode:
Phone (H):	(W):
Mobile:	
Date of Birth:	
Country of Birth:	
Partner's Name:	Mobile:
Language Spoken at Home:	
Interpreter Required: <input type="checkbox"/> Yes <input type="checkbox"/> No Language:	

PLEASE INDICATE TYPE OF SECONDARY SERVICES UTILISED

<input type="checkbox"/> FCC/Day Stay Name: _____
<input type="checkbox"/> Paediatrician Name: _____
<input type="checkbox"/> C&FHN Secondary Specialist Name: _____
<input type="checkbox"/> Other Name: _____

PLEASE TICK PREFERRED SERVICE:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Canterbury ☎(02) 9787 0827 | <input type="checkbox"/> Nepean ☎(02) 4734 2124 | <input type="checkbox"/> Willoughby ☎(02) 8962 8300 | <input type="checkbox"/> Wollstonecraft ☎(02) 9432 4000 |
| [] Residential | [] Residential | [] Residential | [] Day Stay |
| [] Day Stay | [] Day Stay | | [] Outreach |
| [] Outreach | | | |

**Day Stay/Outreach clients will be contacted by Centre
 Please advise the client to contact the Centre referred to after 3 working days.**

Tresillian use only:	<input type="checkbox"/> URGENT (within 7 days)	<input type="checkbox"/> HIGH PRIORITY	<input type="checkbox"/> ROUTINE
Comments:			

Baby's Surname:

First and Second Name(s):

INFORMATION FROM REFERRING AGENT

Current Problem _____

Settling Issues _____

Feeding Issues _____
 Breast Solids Formula _____
Name of Formula: _____

Relevant Medical Conditions and Management/ Medication: _____

Mental Health Issues and Management
EPDS Date: / /
Score: Q10:
Psychosocial screening attended
 Yes, please attach No

Social Issues and Support

DOCS involvement: Yes No
Case Manager:
Phone No:
Child at Risk Issues: Yes No
Outcome of risk issues?

Domestic Violence Screening
Attended: Yes No
Outcome of DV issues?

Other issues and/or stressors:

Other Agencies involved:

Do you want Centralised Intake to contact you to further discuss this referral? Yes No
If Yes, preferred availability: Day: Time:

Please attach any relevant information eg Mental Health Assessments, Paediatric Reports, OT/Speech Therapy Assessment etc