Queensland Government

Children's Health Queensland Hospital and Health Service

Specialist Referral

Medical Objects ID **RQ402900084**

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F ☐ I

FAX REFERRAL TO 1300 407 281

PATIENT DETAILS [Referral of new patients are accepted before their 16th birthday]

Surname: **Given names:**

Date of birth: **Age:** **UR:**

1. Sex recorded at birth: ☐ Male ☐ Female ☐ Please specify:

2. Gender: ☐ Boy / male ☐ Girl / female ☐ Non binary person ☐ Different term - specify:

Aboriginal or Torres Strait Islander origin: ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither

Medicare eligible: ☐ No ☐ Yes ▸ Card number: Card reference: Expiry: /

Address:

Suburb: **Postcode:** **Ph (H):** **Mobile:**

Parent/Guardian/Agency name: **Relationship to patient:**

Parent/Guardian/Agency contact details:

Interpreter required? ☐ No ☐ Yes ▸ preferred language:

Is child in out of home care? ☐ No ☐ Yes ▸ Child Safety Service Centre:

Are there any custody or guardianship issues? ☐ Yes ☐ No

Facility referred from: **Facility URN:**

Length of referral and designation

☐ SMO/VMO/Specialist (3 months) ☐ Registrar/Resident (12 months) **GPs** ▸ ☐ Indefinite ☐ 12 months ☐ Telehealth referral

Is the referral urgent? ☐ Yes ☐ No If **yes**, please explain why:

Refer to a Specialty by selecting a ☑ **Head of Clinic** or completing the specialty field below. Referrals are shared with other Specialists in the clinic to ensure patients are seen as quickly as possible.

Please note: Referrals to Genetic Health Queensland or Children's Oral Health are to be made to the Metro North Hospital and Health service

Burns
☐ Prof Roy Kimble
[Fax: **3068 4329**]

Cardiac Surgery
☐ Dr Prem Venugopal
[Fax: **3068 4329**]

Cardiology
☐ Dr Timothy Colen
[Fax: **3068 4329**]

Child Development
☐ Dr Helen Heussler

☐ **Child Health Service**

Childhood Hearing Clinics
☐ Dr Helen Heussler

Child Protection & Forensic Medical Services
☐ Dr Jan Connors

Cleft & Cranio-facial
☐ Dr Yun Phua

Dermatology
☐ Dr Tania Zappala

Endocrinology/Diabetes
☐ Dr Tony Huynh

ENT/Otolaryngology
☐ Dr Nicola Slee

Immunology & Allergy
☐ Dr Jane Peake

Fracture Clinic
☐ Dr David Bade
[Fax: **3068 4329**]

Gait/Motion Analysis
☐ Dr John Walsh
Specialist only

Gastroenterology & Hepatology
☐ Dr Nikhil Thapar

Gender Clinic
☐ Dr Brian Ross

General Paediatrics
☐ Dr Kate Davies

Haematology
☐ Dr Jeremy Robertson
[Fax: **3068 4329**]

Immunisation Specialist Services
☐ Dr Sophie Wen

Infectious Diseases
☐ Dr Julia Clark

Metabolic Medicine
Director - Anita Inwood
☐ Dr Coman / Lipke / Bursle

Nephrology
☐ Dr Peter Trnka

Neurology
☐ Dr Sophie Calvert

Neurosurgery
☐ Dr Robert Campbell
[Fax: **3068 4329**]

Obesity
☐ Dr Anne Kynaston
QCH catchment only

Oncology
☐ Dr Wayne Nicholls
For all Oncology referrals phone QCH on 3068 1111 - request to speak with the Oncologist on call

Opthalmology
☐ Dr Shuan Dai

Oral & Maxillofacial Surgery
☐ Dr Ben Erzetic

Orthopaedic Surgery
☐ Dr David Bade

Paediatric Surgery & Urology
☐ Prof Roy Kimble

Paediatric & Adolescent Gynaecology
☐ Prof Rebecca Kimble

Pain Clinic
☐ Dr Mark Alcock

Palliative Care
☐ Dr Anthony Herbert

Plastic & Reconstructive Surgery
☐ Dr Yun Phua

Rehabilitation/ Cerebral Palsy Health
☐ Dr Priya Edwards

Respiratory/Sleep Medicine
☐ Prof Alan Isles

Rheumatology
☐ Dr Ben Whitehead

Sleep Clinic
☐ Dr David Kilner

Vascular Malformations
☐ Prof Roy Kimble

Specialty:

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Family Name:

Given Names:

Address:

Date of Birth:

Patient name: **Date of birth:** **URN:**

REASON FOR REFERRAL (problem to be addressed)

Background – history of presenting complaint & clinical question: (comment on duration, severity, and treatment to date)

Past medical history:

Current medications:

Allergies:

Immunisation status:

Social history and/or psychosocial risk factor/s: (comment on home visit safety)

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Given Names:

Address:

Date of Birth:

Patient name:	**Date of birth:**	**URN:**

Relevant family history:

DEVELOPMENTAL ASSESSMENT [for referrals to Child Development Service]

Thinking and Learning (Attention, learning new things, planning and problem solving, engagement at school/childcare)
☐ No concerns ☐ Concerns – details:

Communication (understanding, expressing self, clarity of speech)
☐ No concerns ☐ Concerns – details:

Social Skills and Play (Interaction and play with peers, underlying play skills and interests)
☐ No concerns ☐ Concerns – details:

Movement Skills (gross and fine motor skills, symmetry)
☐ No concerns ☐ Concerns – details:

Activities of Family Living and Independence (Mealtimes, dressing, toileting, sleep)
☐ No concerns ☐ Concerns – details:

Emotional Wellbeing Skills (Managing emotions + behaviour for age (e.g. escalation, withdrawal, length of time))
☐ No concerns ☐ Concerns – details:

Supporting documentation (please select and attach):

☐ Information from school/kindy/childcare
☐ Allied Health reports
☐ Guidance Officer reports
☐ Paediatrician or other specialist reports
☐ Other (specify):

RELEVANT INVESTIGATIONS ▸ PLEASE ATTACH COPIES

REFERRING DOCTOR [Please complete all sections legibly – incomplete referrals will be returned]

DR surname	**DR given name**	**Provider #**
Hospital	**Unit**	**Department**
Phone	**Fax**	**Pager**

Is anyone else involved in the care of this patient?	**Date:**	**Time:**	**Signature:**

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SUBMIT