



Children's Health Queensland  
Hospital and Health Service

## Ellen Barron Family Centre Referral

**EBFC USE ONLY**

Affix ieMR PARENT/CAREGIVER identification label here

DATE OF REFERRAL:

Service type:  Inpatient  Telehealth

**REFERRING HEALTH PROFESSIONAL**

First name	Surname	Designation
Organisation		
Postal Address	Suburb	Postcode
Phone	Fax	Email

**DETAILS OF PARENT / CARER**

Full name	Full name
Previous surname	Previous surname
Date of birth	Date of birth
Birth country	Birth country
Address	Address
Suburb	Postcode
Suburb	Postcode
Sex	Sex
Relationship status	Relationship status
Indigenous status	Indigenous status
Home phone	Mobile
Home phone	Mobile
Email	Email
Interpreter required? <input type="checkbox"/> Yes <input type="checkbox"/> No	Interpreter required? <input type="checkbox"/> Yes <input type="checkbox"/> No
Language	Language

**CHILD / CHILDREN WITH PRESENTING CONCERN**

Full Name	Full Name
Date of birth	Age
Date of birth	Age
Country of birth	Country of birth
Address	Address
Suburb	Postcode
Suburb	Postcode
Sex	Sex
Indigenous status	Indigenous status
Bed required? <input type="checkbox"/> Cot <input type="checkbox"/> Toddler Bed	Bed required? <input type="checkbox"/> Cot <input type="checkbox"/> Toddler Bed

**CHILD / CHILDREN REQUIRING ADMISSION AS BOARDER ONLY**

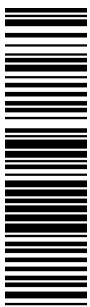
Full Name	Full Name
Date of birth	Age
Date of birth	Age
Country of birth	Country of birth
Address	Address
Suburb	Postcode
Suburb	Postcode
Sex	Sex
Bed required? <input type="checkbox"/> Cot <input type="checkbox"/> Toddler Bed	Bed required? <input type="checkbox"/> Cot <input type="checkbox"/> Toddler Bed

**NEXT OF KIN DETAILS FOR PARENT / CAREGIVER**

Name	Date of birth
Address	Relationship to parent/caregiver
Name	Date of birth
Address	Relationship to parent/caregiver

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v8.00 - 06/2023



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Please add as much detail as possible when completing the sections below. Failure to provide adequate information will delay the admission progression. **NOTE: Co-sleeping is not supported at Ellen Barron Family Centre.**

**REASON FOR REFERRAL** (problem to be addressed, history of presenting concerns)

**Sleep / settling** (provide details of current settling)

**Feeding issues - breastfeeding / bottle feeding / solids** (provide details)

**Behaviour** (provide details)

**Other** (provide details)

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CHILD 1		CHILD 2	
Name		Name	
Is the infant/child: <input type="checkbox"/> Breast fed <input type="checkbox"/> Bottle fed <input type="checkbox"/> On solids		Is the infant/child: <input type="checkbox"/> Breast fed <input type="checkbox"/> Bottle fed <input type="checkbox"/> On solids	
Birth weight	Current weight	Birth weight	Current weight
Is there a concern with the child's weight? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is there a concern with the child's weight? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Relevant medical or developmental history		Relevant medical or developmental history	
Current medication for child		Current medication for child	
Current medication for parent			

Disability aids required?  Yes  No

**PARENT / CARER INFORMATION**

**Parent's Mental Health**

Have there been any episodes of diagnosed emotional/mental illness in the past 5 years where the parent/carer sought medical advice and/or counselling?  Yes  No

**Please provide further information on mental health support that has been provided for the parent**

**Relevant issues regarding the caregiver e.g. substance abuse, trauma, social isolation, physical health/disability, learning/intellectual disability, domestic violence. If yes, provide details**

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**PARENT / CARER INFORMATION**

Are there concerns regarding the parent-child relationship? If yes, provide details

Are there any current child protection concerns? If yes, provide details

Are Child Safety Services involved?  Yes  No

Child Safety Service Centre:

Contact person

Phone

Child Protection Order/Intervention

Family supports

Provide any additional relevant information that will be important for staff when reviewing this referral?

Have you discussed the referral and the information provided with the parent?

*If not, why?*

What other agents are currently providing services to the family?

- |  |   |
|--|---|
| <input type="checkbox"/> 0-4 CYMHS / CYMHS services                                | <input type="checkbox"/> Paediatrician service                                  |
| <input type="checkbox"/> Adult Mental Health clinician                             | <input type="checkbox"/> Previous admission to Ellen Barron Family Centre       |
| <input type="checkbox"/> Child Health Centre / day-stay / parent management clinic | <input type="checkbox"/> Previous admission to other residential/patient centre |
| <input type="checkbox"/> Department of Child Safety, Youth & Women                 | <input type="checkbox"/> Psychiatrist   |
| <input type="checkbox"/> Intensive Family Support Service                          | <input type="checkbox"/> Other - specify:                                       |
| <input type="checkbox"/> General Practitioner                                      |   |
| <input type="checkbox"/> Paediatric Allied Health - specify:                       |   |

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Additional information:

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*Please ensure all details are completed on all pages for prompt assessment of the referral.*

<b>Name</b>		<b>Signature</b>
<b>Designation</b>	<b>Date</b>	

**External to Queensland Health please consider the Privacy Obligations for secure sending of Health Information.  
Please FAX your completed form to 07 3068 3719**

Queensland Health staff can submit a referral by printing the completed form and either:

1. Emailing the completed PDF form to [EBFC-Referrals@health.qld.gov.au](mailto:EBFC-Referrals@health.qld.gov.au)
2. Or printing and faxing to **07 3068 3719**