Queensland Government

Children's Health Queensland Hospital and Health Service

Referral to Good Start Program

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F ☐ I

☐ **OUTPATIENT REFERRAL**
Duration: ☐ 3 months ☐ 12 months
☐ **New Referral**
☐ **Continuation**

Parent / Guardian name/s:

Interpreter? ☐ Yes ☐ No Language:

Does the child reside within the Metro South Region? *(Refer to our Pre-Referral Guidelines over page)*
☐ Yes ☐ No If ***yes***, please complete the details below

Child's Details

Family name: **Given name/s:**

Preferred name:

Date of birth: **Sex:** ☐ Male ☐ Female ☐ Other

Address: **Suburb:** **Postcode:**

Country of birth: If ***Australia***, was the child born in Queensland? ☐ Yes ☐ No

General Practitioner (GP) details:

Pre-assessment Questions (please answer **ALL** questions to determine whether your patient is appropriate for our Program)

Have you received consent from the child's parent/guardian for this referral? ☐ Yes ☐ No

What is the patient's BMI percentile? ☐ >85 ☐ >95 ☐ >99

Does the patient have any of the following medical conditions? ☐ Yes ☐ No If ***yes***, please indicate
☐ Hypertension ☐ Type 2 Diabetes ☐ Dyslipidaemia
☐ Hepatic Steatosis ☐ Obstructive Sleep Apnoea ☐ Other:

Has the MSE (Mental State Exam)/HEADSS/other Mental Health Screen been completed? ☐ Yes ☐ No
If ***yes***, please attach.

Have there been any behavioural or neurodevelopmental concerns identified? ☐ Yes ☐ No
If ***yes***, provide details:

Are Child Safety/FACC/IFS/Family Services involved? ☐ Yes ☐ No
If ***yes***, provide details:

Additional information:

Supporting documentation attached: ☐ Yes ☐ No
If ***yes***, please select from the following: ☐ Pathology results ☐ Mental Health Assessment

Referrer

Name:	**Profession:**	**Provider number:**
Organisation/GP Practice name:		
Address:		
Email:	**Phone:**	**Fax:**

Please fax to OPD Contact Centre – 3068 3339

If fax is not available, please complete referral form, Consent for Email Communication (see below) and email to CHQ-REF@health.qld.gov.au

DO NOT WRITE IN THIS BINDING MARGIN

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Queensland Government

Good Start Program
Children's Health Queensland Hospital and Health Service

The Healthy Kids Club

Paediatric Weight Management and Type 2 Diabetes Clinic

The Logan Multidisciplinary Paediatric Obesity and Type 2 diabetes clinic is conducted by Children's Health Queensland (CHQ) clinicians. The clinic manages obesity and type 2 diabetes in children and adolescents in the Logan area and receives referrals from Metro South region and Queensland Children's Hospital.

Clinic details

Clinics are held at Browns Plains on Tuesdays and Fridays and at Logan Central on Wednesdays. Outreach services are available in the Logan area only. Families are offered intensive support from the multidisciplinary team using a family centred approach for care with weight management and type 2 diabetes.

The weight management team consists of a multicultural health worker, dietitian, physiotherapist, nurse/diabetes educator, and social worker.

Referral Criteria

Inclusion

Any child from birth to 18 years who meets one or more of the following criteria:

For weight management

- Referred by Health Professionals, Education and Community Services.
- 0-2 with a BMI > 97th percentile on the WHO growth chart and gaining weight rapidly, or who has been assessed by a paediatrician or general practitioner (GP) to have weight concerns (i.e. above the healthy weight range).
- 2-18 with a BMI ≥ 85th percentile on the US-CDC or WHO growth charts.
- Consent gained for referral from parents/carers.
- Willingness from families to commit to regular appointments.

For Type 2 diabetes

- All referrals to our service are sent via the Endocrinology department at the Queensland Children's Hospital.

Exclusion

- Conditions identified as secondary or genetic causes of obesity.
- Mental health/ behavioural concerns that are not well managed.

The Healthy Kids Club – Paediatric Weight Management and Type 2 Diabetes Clinic conducts appointments within the Metro South region via face to face, phone or Telehealth.

We only provide outreach options to the catchment areas below:

Logan Catchment Suburbs

4123 Rochedale South
4124 Greenbank
4125 Park Ridge
4280 Jimboomba, North and South Maclean
4207 Beenleigh, Eagleby, Yarrabilba, Logan Village
4205 Bethania
4127 Daisy Hill, Springwood
4128 Shailer Park, Tanah Merah
4130 Loganholme, Cornubia
4131 Meadowbrook
4132 Marsden
4133 Logan Reserve, Waterford, Crestmead
4114 Logan Central, Woodridge, Kingston
4118 Browns Plains
4119 Underwood

Queensland Government

Children's Health Queensland Hospital and Health Service

Consent for Email Communication

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F ☐ I

Children's Health Queensland offers patients/guardians the opportunity to communicate by email. This form provides information about the risks of email, conditions for use of email communication and how email communication will be used. It will also be used to document your consent to communicate with you by email.

Patient's name:

Patient / Guardian email address:

Health Care Professional:

Email address: **Contact phone number:**

Risks

Communication by email has a number of risks which include, but are not limited to, the following:

1. The health care professional cannot guarantee that any particular email will be read or responded to.
2. Email can be circulated, forwarded and stored in paper and electronic files.
3. Backup copies of email may exist even after the sender or the recipient has deleted his/her copy.
4. Email senders can easily misaddress an email or email can be received by unintended recipients.
5. Email can be intercepted, altered, forwarded or used without authorisation or detection.
6. Employers and on-line services have a right to archive and inspect emails transmitted through their systems.

Conditions for the use of Email

1. The health care professional will use reasonable means to protect the security and confidentiality of email information sent and received. However, because of the risks outlined above, the health care professional cannot guarantee the security and confidentiality of email communication, and Children's Health Queensland will not be liable for the inadvertent disclosure of confidential information.
2. Email is not appropriate for urgent or emergency situations, nor is it a substitute for care that may be provided during a face-to-face visit or a telephone/telehealth consultation.
3. I will inform the health care professional of email address changes.
4. When emailing a health care professional, I will:
   (a) Put the patient's name, date of birth and patient record number (URN) in the body of the email, not in the subject line.
   (b) Include the general topic of the message in the email's subject line. For example 'advice' or 'appointment'.
   (c) Contact the health care professional's office via alternative communication methods (phone, letter etc) if a reply is not received within a reasonable period of time.
5. I will not use email for communication regarding sensitive medical information.
6. I am responsible for informing the health care professional of any types of information that I do not want to be sent by email.
7. I am responsible for protecting my password or other means of access to email. The health care professional is not liable for breaches of confidentiality caused by myself or any third party.

Collection Notice

1. Queensland Health is required to manage my personal information in accordance with the *Information Privacy Act 2009* and the *Hospital and Health Boards Act 2011*. Queensland Health (QH) is collecting the personal information on this form for the purpose of facilitating email communication between patients/guardians and their health care professional.
2. Email communication between myself and the health care professional will be printed and filed in my patient medical record. As emails are a part of the medical record, other individuals authorised to access the medical record will have access to those emails.
3. Email messages from myself may also be delegated to another health care professional or staff member for response. Administration staff may also receive and read or respond to my emails.
4. Some of my personal information on my medical record may be given to carers, guardians or other government departments who provide associated services that require my information for the purpose of providing a health care service. My information may be disclosed without my consent if authorised or required by law. For further information I can ask for a copy of the *Queensland Health Privacy Brochure*.

Patient/Guardian Agreement and Acknowledgement

I have read and fully understand this consent form. I understand the risks associated with the communication of email between the health care professional and me. I consent to the conditions for the use of email outlined above, as well as any other instructions the health care professional may communicate to me.

Patient / Guardian's name: **Patient / Guardian's signature:**

Date: / /

DO NOT WRITE IN THIS BINDING MARGIN

v7.00 - 01/2017