**Strong Mums Solid Kids External Referral Form**

**Please fax completed form to:** Attention of SMSK 08 8223 7658

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **Personal Information** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Given Name** |  | | | | | | | | | | | | **Surname** | | | | | | |  | | | | | | | | | | |
| **Preferred Name (If different from given name):** | | | | | | |  | | | | | | | | | | **Date of Birth:** | | | | | | | | | / / | | | | |
| **Please tick:** | | 🞎 Aboriginal | | | | | | 🞎 Torres Strait Islander | | | | | | | | 🞎 Aboriginal & TSI | | | | | | | | | | | 🞎 Non-Aboriginal | | | |
| **Address** | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Suburb / Town** | | | | | |  | | | | | | | | | | | | | | | | | **Postcode** | | | |  | | | |
| **Contact Number** | | | | | |  | | | | | | | | **Email:** | | | |  | | | | | | | | | | | | |
| **referral information** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Date of Referral** | | | | | / / | | | | | | | **Referral To:** | | | | | | | | | | 🞎 Maternal Health 🞎 Child Health  🞎 Healthy Ears  🞎 Perinatal Mental Health Clinician | | | | | | | | |
| **Referred By** | |  | | | | | | | | | | | | | **Contact Number** | | | | | | | | | |  | | | | | |
| **Agency Name** | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Has the client consented to this referral?** | | | | | | | | | | | 🞎 Yes 🞎 No | | | | | | | | **Is this referral urgent?** | | | | | | | | | 🞎 Yes 🞎 No | | |
| **Reason for Referral** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 🞎 **Pregnancy** | | | | | | **Gestation / EDD** | | | |  | | | | | | | | | | | | | | **Pregnancy Number** | | | | |  | |
| 🞎 **Post Natal** | | | **Date of Delivery** | | | | | | / / | | | | | | | | | | | | **Child number for parent** | | | | | | | | |  |
| 🞎 **Child Health** | | | | | | **Name of Parent or Carer if not parent** | | | | | | | | | | | | | | |  | | | | | | | | | |
| 🞎 **Healthy Ears Name of Parent or Carer if not parent** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  🞎 **Perinatal Mental Health Clinician** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Requested care / reason for referral:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Other Services Involved:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Other relevant information:** *(i.e. Medical issues, SEWB etc)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| **Feedback Required** | 🞎 Yes 🞎 No | |
| **Contact details for feedback** | |  |