**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** |   |