HUNTER NEW ENGLAND
LOCAL HEALTH DISTRICT
FIRST STEPS PARENTING CENTRE

Fax Referral to : 4924 6555
OR Email: hnelhd-firststepsparenting@hnehealth.nsw.gov.au
Telephone: 4924 6550

FAMILY NAME		MRN
GIVEN NAMES		☐ MALE ☐ FEMALE
D.O.B. ____/____/____	M.O.	
ADDRESS		
LOCATION		
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE		

PART 1 – CHILD AND PRIMARY CARERS

Date: ________ / ________ / 20 ______

Does Parent/Primary Carer give consent for referral ☐Yes

OFFICE USE ONLY

Chime____	E doc____	Scanned____	S/R________
Apt Date:________	Apt Time:________	Clinician________	
Ref attached:____	Letter sent:________	Venue:________	
Accepted________	DNA letter:________	Expired:________	

REFERRED CHILD: ☐ Female ☐ Male ☐Unborn *EDC* ____________

HNE HEALTH USE ONLY
MRN: ______________

Surname: ______________ *Given Name*: ______________

Date of Birth: ____ / ____ / ________ *Age*: ____ *years*, ____ *months* *Hospital of birth*: ____________

INDIGENOUS STATUS: ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither

PARENT(S) / CARER(S):

1. *Surname*: ______________ *Given Name*: ______________

HNE Health Use Only
MRN: ______________

Date of birth: ______________ *Age*: ______ *years*

Relationship to child: ______________________ *Maiden Name*: ______________

INDIGENOUS STATUS: ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither

2. *Surname*: ______________ *Given Name*: ______________

HNE Health Use Only
MRN: ______________

Date of birth: ______________ *Age*: ______ years

Relationship to child: ______________________ *Maiden Name*: ______________

INDIGENOUS STATUS: ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither

FAMILY CONTACT AND OTHER DETAILS:

Home address: ______________________ *Suburb*: ______________ *Postcode*: ________

Can we send mail to this address ☐Yes ☐No

Tel: (Home): ______________ *Mobile*: ______________________

Email Address: ______________________________________

Medicare No ☐☐☐☐ ☐☐☐☐☐ ☐ *Position on card* ☐

Family GP: *Dr.* ______________________ *Phone*: ______________

Address: ______________________________________

This form is to be scanned into BOTH the Mothers and Babies CHIME health records

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SIBLING DETAILS: (Please record additional siblings on paper and attach to this form)

Sibling 1: ______________ ☐ Female ☐ Male *DOB*: ______

Sibling 2: ______________ ☐ Female ☐ Male *DOB*: ______

Sibling 3: ______________ ☐ Female ☐ Male *DOB*: ______

REFERRER DETAILS: *Name* ______________ *Relationship to client*: ______________

Agency and address: ______________ *Postcode* ______

Phone: ______________

Email: ______________

LANGUAGE: *Preferred language*: ______________

Interpreter: ☐ Not required ☐ Required *If required, for whom* ______________

Service Requested for Family

- ☐ Young Parents Network (Maitland/Port Stephens)
- ☐ PND Support
- ☐ Parent-Child Relationship/Attachment
- ☐ PIPS (JHH Maternity Staff Only). PIPS Case Conference time options ______________
- ☐ Counselling
- ☐ Sleep & Settle
- ☐ Child Behaviour
- ☐ Other ______________

Current issues relating to Parent/Caregiver:

- ☐ Mental Health
- ☐ Edinburgh Postnatal Depression scale Date ______ Score ______ Q 10 ______
- ☐ Domestic violence
- ☐ Alcohol/drug use
- ☐ Housing
- ☐ Legal/criminal/AVO
- ☐ Family conflict

Current Issues Relating to Child:

- ☐ Sleep/settling
- ☐ Feeding
- ☐ Behaviour
- ☐ Parent-child relationship/attachment
- ☐ Health issues
- ☐ Milestones
- ☐ Child at risk

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REVISION DATE 21st October 2016

*Please describe in more depth the **CHILD** related concerns/behaviours; current and previous interventions for the **CHILD**; duration and context of the current issues; any other **CHILD** related information. **(parent/carer issues over page).***

____

Sign________________Print________________Designate________________Date__________

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PART 2 – PRIMARY CARERS DETAILS ONLY

Date: ________ / ________ / 20 ______

Does Parent/Primary Carer give consent for referral ☐Yes

OFFICE USE ONLY

Chime______ **E doc**______ **Scanned**______ **S/R**____________

Apt Date:__________ **Apt Time:**__________ **Clinician**__________

Ref attached:______ **Letter sent:**__________ **Venue:**__________

Accepted__________ **DNA letter:**__________ **Expired:**__________

OTHER PROFESSIONALS / AGENCIES INVOLVED WITH INFANT / CHILD / YOUTH / FAMILY: ***Please consider health, education and community welfare services and note names, discipline and contacts of professionals.***

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Please elaborate on ***Parent/Care Giver Issues:***

____
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____

Has the referrer home visited the family? ☐ Yes ☐ No

Are there any workers safety concerns related to home visiting? ☐ Yes ☐ No ☐ Not known

Sign________________ Print________________ Designate________________ Date____________

REVISION DATE 21st October 2016

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