HNEkidshealth
Children, Young People & Families

NSW GOVERNMENT Health
Hunter New England
Local Health District

# *Child Development Team – Referral Form*

*Email: HNELHD-ChildDevelopmentTeam@health.nsw.gov.au*

*Phone: (02) 4924 6400*

THE CHILD DEVELOPMENT TEAM IS AN ASSESSMENT ONLY SERVICE. WE DO NOT PROVIDE ONGOING THERAPY. PLEASE FILL OUT THE FORM **ELECTRONICALLY** AND RETURN TO TEAM VIA EMAIL.

| Date of referral | |
|---|---|

## Which developmental assessment are you requesting for the child (tick as many as apply)

| | | | |
|---|---|---|---|
| Autism Spectrum Disorder | | Fetal Alcohol Spectrum Disorder (confirmed alcohol exposure) | |
| Learning Disorder | | Global Developmental Delay and/or Cognitive Delay | |
| Other (describe) | | | |

## Child's Information

| | | | | | |
|---|---|---|---|---|---|
| Surname | | | Given name | | |
| Date of birth | | Age | | Sex at Birth | |
| Home address | | | | | |
| Does the child identify as | Aboriginal | | Torres Strait Islander | | |
| Is the child culturally and linguistically diverse? Requires an interpreter | | | | Language | |

## Contact Person

| | | | |
|---|---|---|---|
| Name | | Relationship to Child | |
| Legal guardian of Child | | | |
| Is the child in Out of Home Care e.g. Foster care, kinship care, adopted? | | | |
| Mailing address | | | |
| Phone number | | Email address | |

## Consent

| | | | | |
|---|---|---|---|---|
| This referral cannot be processed without the consent from either the child's parent or legal guardian | | | | |
| Name | | Parent | | Legal Guardian |

## Referrer Details

| | | | |
|---|---|---|---|
| Surname | | Given name | |
| Title/relationship to Child | | | |
| Agency name | | | |
| Mailing address | | | |
| Phone number | | Email address | |

## GP Details (if different from referrer)

| | | | |
|---|---|---|---|
| Surname | | Given name | |
| Name of practice and/or address | | | |
| Phone number | | Email address | |

| | | |
|---|---|---|
| Do you have or have you applied for the NDIS/Early Intervention? | Yes | No |
| Do you have or have been referred to a Paediatrician? Yes No<br>Drs Name & clinic: | | |
| Are you aware of any psychosocial factors impacting the family? Homelessness Domestic Violence<br>Parent or carer mental health Child protection concerns Out of home care | | |

As a general guide the Child Development Team will accept referrals where:

1. The child lives in the Greater Newcastle and Hunter Valley clusters of Hunter New England Local Health District
2. The child is between the ages of 18 months and 12 years and has not commenced High School
3. The child presents with significant delays in two or more of the following developmental domains:
   - Significant delays with receptive, expressive and/or social communication language and/or social interaction
   - Significant difficulties with fine and/or gross motor skills
   - Significant delays in the area of cognition and/or learning e.g. pre-academic or academic skills
   - Significant difficulties in day-to-day functioning e.g. activities of daily living, living skills, and/or atypical restricted/repetitive patterns of behaviour/interests/activities

**Clinical Concerns:** Please provide illustrative examples, screening tool results, assessment results and diagnoses in the boxes below

***Two or more boxes need to be demonstrated as a concern for the referral to be accepted*.**

| |
|---|
| Significant delays with receptive, expressive and/or social communication language and/or social interaction |
| Significant difficulties with fine and/or gross motor skills |
| Significant delays in the area of cognition and/or learning |
| Significant difficulties in day-to-day functioning |