**Referral to Transition Service** **Date:**

|  |  |  |
| --- | --- | --- |
| **Hospital /Service name**       | **SUPI/ MRN**      | **Care plan completed**Yes [ ]  No**[ ]**  |
| **Surname**      | **First name**      | **Date of birth**      | **Gender**Male [ ]  Female [ ]  |
| **Address**      | **Aboriginal or Torres Strait Islander origin**Yes [ ]  No [ ]  |
| **Home phone number**      | **Mobile number and email address**      |
| **Other reliable contact**      **Relationship to person referred**       |  Address of other contact      | **Phone number of other contact**     **Mobile number**     **Email address**      |
| **Interpreter required** Yes [ ]  No [ ]  Language**:**       | **Help required with communication**  Yes [ ]  No [ ]  |
| **Primary diagnosis**       | **Co-morbidities**      |
| **Reason for transfer to adult services and any priorities for management**      |
| **GP details** **Name**      **Address**      **Phone or email contact**       |
| **Education / employment status** [ ]  School (which year)       [ ]  Preparing for Uni /TAFE [ ]  TAFE [ ]  University [ ]  Working - Full-time [ ]  or Part-time [ ]  [ ]  Unemployed [ ]  Other  |
| **Paediatric service details (list all clinicians involved and their speciality)**      | **Proposed adult service details (list all relevant clinicians and their speciality)**      |
| **Recommended first appointment at adult service**      **Location:**  | **Name of person making referral:**     **Signature of person making referral:** **Facility/Department/Agency/Other:**      |

**Consent:** I agree for this referral to be passed onto the Transition Service and to be contacted by the staff of the Transition Service

**Name:** **Signature:**

Please fax completed form to Angie Myles Transition Care Coordinator. Fax: 49257955