**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