**Referral to ACI Transition Service Northern Region / HNEKidshealth**

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| **Hospital /Service name**  Enter Text | | | **Paediatric MRN**  Enter Text | | | | | **Referred by**  Enter Text | | | | | | **Date** | | |
| **Surname**  Enter Text | | **First name:** Given Name    **Preferred name:** Enter Text | | | | | | | **Date of birth**  Date | **Gender**  Male  Non-Binary  Female  Other | | | | | | **Pronoun**  He  She  They |
| **Address**  Address | | | | | | | | | **Aboriginal or Torres Strait Islander origin:**  YES  NO  N/A | | | | | | | |
| **Home phone number:** Number | | | | | | | | **Mobile number:** Number | | | | | | | | |
| **Email address:** Email | | | | | | | | | | | | | | | | |
| **Nominated Contact**  Name  **Relationship**  Family/Carer | | | | Address of nominated contact If different from above | | | | | | | | **Phone number of nominated contact**  Contact number  **Email**  Email | | | | |
| **CALD: YES  NO**  **Interpreter required: YES  NO**  Language**:** Language | | | | | | | **Help required with communication: YES  NO**  Describe best communication method | | | | | | | | | |
| **Primary diagnosis**  Enter text | | | | | | | **Co-morbidities (other medical conditions)**  Enter text | | | | | | | | | |
| **Priorities for management**  Enter text | | | | | | | | | | | | | | | | |
| **GP details:** Enter text | | | | | | | | **Medicare #** Enter text  **Ref:** Enter text  **Expiry:**  Enter text | | | | | | | | |
| **Education / employment status**  School – Year level? Enter text  Preparing for Uni /TAFE  TAFE | | | | | University  Working - Full-time  or Part-time  Unemployed / Seeking Employment | | | | | | | | Other ………………………… | | | |
| **PAEDIATRIC service details** | | | | | | | | **ADULT service details** | | | | | | | | |
| **Name**  E.g. Dr. John SMITH | **Specialty**  Neurology | | | | | **Hospital/Service**  CHW | | **Name**  Name | | | **Specialty**  Specialty | | | | **Hospital/Service**  Enter Text | |
| **Recommended first appointment at adult service:**  Enter Text | | | | | | | | **Name of person making referral:**  Enter Text | | | | | | | | |
| **Date:** Enter Text | | | | | | | | **Signature of person making referral:** | | | | | | | | |
| **Location:** Enter Text | | | | | | | | **Facility/Department/Agency/Other:** Enter Text | | | | | | | | |

**Consent:** Please ensure that the young person or carer has provided consent for this referral to be passed onto the Transition Service and to be contacted by the staff of the Transition Service.

**Name: Signature:**

**Please email referral to** [**HNELHD-TransitionCareYoungPerson@health.nsw.gov.au**](mailto:HNELHD-TransitionCareYoungPerson@health.nsw.gov.au)