REFUGEE CHILD CLINIC REFERRAL FORM

SCHN Children's Refugee Service
Sydney Children's Hospital
Attention: Assoc Prof Karen Zwi

Please complete a separate form for each child. Referral from a GP, paediatrician or refugee service is appreciated.

The referrer and/ or child's carer may be contacted and asked to provide further information. This is in order to help us understand the child and their health, developmental and behavioural needs.

Date: _____/_____/_____

Patient's Personal Details

First name: _____ Surname: _____

DOB: dd/mm/yy _____/_____/_____ Age: (this year) _____ ☐ Male ☐ Female

Address:

Interpreter required: ☐ Yes ☐ No Preferred language: _____

Country of birth: _____ Australia arrival date: dd/mm/yy: _____/_____/_____

Medicare number: _____

If Medicare ineligible, is the patient a client of any of the following services:

☐ IHMS client (community detention) ☐ Life without Barriers ☐ Red Cross ☐ Marist Youth
☐ Settlement Services Int. ☐ No ☐ Unknown

Migration Status

Refugee: ☐ No ☐ Yes ➤ Visa Type (if known): _____

Asylum Seeker ☐ No ☐ Yes

Person to Contact

Name: _____ Relationship to child: _____

Interpreter required: ☐ No ☐ Yes

Email: _____ Phone: _____

Reason for Referral: (Include clinical findings, management to date, relevant medical and social history, immunisation status, and special needs)

(more space overleaf)

Specify medication taken and any allergies _____

Other referrals made: _____

GP/Paediatrician Details

Name: _____

Phone: _____ Fax: _____

Address: _____

Provider number: _____ Signature: _____ Print & Sign

Referrer Details (non-GP):

Name: _____ Organisation: _____

Email: _____ Phone: _____

Supporting Doumentation: Please attach any relevant assessments and pathology results.

Fax to 9382 8188 | Email: SCHN-SCH-refugee@health.nsw.gov.au | Enquires: 9382 8472.

Admin Use Only

Date received: _____/_____/_____

When to be seen: ☐ within 1 month ☐ within 3 months ☐ within 6 months

Appointment date, time and location: _____

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Additional patient details: