



Royal Queensland Bush Children's Health Scheme REFERRAL INFORMATION

For referral to Bush Children's Program please complete and return to your location BUSHkids Centre.

CLIENT DETAILS

Family Name: _____ Given Name/s: _____

Sex: M / F Date of Birth: _____ Age: _____ Country of Birth: _____
(please circle)

Current School / Kindy: _____ Year Level: _____

(Please tick) IEP / EAP Beginning Profile _____ IEP / EAP Profile _____ Neither _____

Please describe special assistance at school (if any): _____

Home Address: _____ Post Code: _____

Postal Address: _____ Post Code: _____

Phone: _____ Mobile Phone: _____ Email: _____

Preferred Language: _____ Family Background: _____
(eg Aboriginal, Torres Strait Islander etc)

FAMILY DETAILS

Name	DOB / Age	Relationship to Child	Occupation (Adults) Year Level at School (Children)
1	_____	_____	_____
2	_____	_____	_____
3	_____	_____	_____
4	_____	_____	_____
5	_____	_____	_____

OTHER SERVICES CURRENTLY INVOLVED WITH CHILD / FAMILY

- Pediatrician
 GP
 School/Child Care centre
 CYMHS
 Dept of Communities
 Dept Child Safety
 Centacare
 Disability Services Queensland
 Community Health

Other: _____

REFERRER INFORMATION

Name: (please print) _____

Position / Job Title: _____

Agency Name: (If applicable) _____

Postal Address: _____ Postcode: _____

Telephone: _____ Facsimile: _____ Email: _____

SIGNATURE: _____ Date: _____

PLEASE TURN OVER TO COMPLETE THE REMAINDER OF THE FORM ➡➡

PRESENTING PROBLEMS

SUMMARY OF RELEVANT HISTORY: (Developmental, Medical, Family, Psychiatric)

HOW DO YOU BELIEVE WE CAN ASSIST THIS CHILD/FAMILY?

IMPORTANT INFORMATION

If receipt of your referral has not been confirmed within one month of sending it, please contact us. Bush Children's takes no responsibility for referral forms that we have not yet received.

This form must be **completed** and **signed** by a parent/guardian before it will be accepted by a Bush Children's Centre.

PARENT / GUARDIAN SIGNATURE

I hereby consent to this referral to the Royal Queensland Bush Children's Health Scheme. I also consent to the exchange of information between Bush Children's, the referrer and nominated agencies/professionals as part of the referral process:

Signature of Parent/Guardian

Date

FOR OFFICE USE ONLY

Date received: _____ Date of CMM: _____ CM Decision: Accepted
 Not accepted
 Pending

Action: _____

Action By (Name/Position): _____

Signature: _____ Date: _____