



Children's Health Queensland
Hospital and Health Service

Referral Form

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth:

Sex: M F

Referrals can be submitted via ▶ Fax: 1300 407 281
Mail: PO Box 3474 South Brisbane QLD 4101

**To ensure a timely appointment, complete all sections of this form.
Incomplete forms will be returned for completion.**

Lady Cilento Children's Hospital
501 Stanley Street, South Brisbane Queensland 4101

Hospital switchboard: (07) 3068 1111

*** Please direct an acutely unwell child to the Emergency Department**

Referred to:

Referral date:

Length of referral: 3 months 12 months Indefinite

Telehealth referral: Yes No

Patient Details

Last name:

First name:

Date of birth:

Age:

Sex: Male Female

Medicare eligible? No Yes ▶ Medicare number:

Expiry:

Residential address:

Suburb:

State:

Postcode:

Postal address (if different from above):

Suburb:

State:

Postcode:

Parent / guardian / agency name:

Relationship to patient:

Preferred contact – Phone:

Mobile:

Is the patient of Aboriginal or Torres Strait Islander origin? Yes No

Interpreter required? No Yes ▶ what is the preferred language?

Referral Details

Reason for referral (please provide as much detail as possible):

DO NOT WRITE IN THIS BINDING MARGIN

REFERRAL FORM

v14.00 - 11/2014



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Family name:	Given names:	URN:
Additional history or comments:		
Please explain if you consider the referral urgent:		
Past history:		
Current medications:		
Allergies:		
Immunisation status: <input type="checkbox"/> Up to date <input type="checkbox"/> Not up to date <input type="checkbox"/> Unknown		
Social history and/or psychosocial risk factor/s:		

DO NOT WRITE IN THIS BINDING MARGIN

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Family name:	Given names:	URN:
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Relevant family history

Relevant Investigations

Are investigations and/or additional documents attached? No Yes ► please list them:

Referring Doctor Details

Doctor:

Provider no:

Practice name:

Practice address:

Suburb:

State:

Postcode:

Phone:

Fax:

Patient's usual GP:

Is anyone else involved in the care of the patient?

Referring doctor's signature:

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You will be notified within three working days (via mail) that your referral has been received. More information about referral processes for the Lady Cilento Children's Hospital and Health Service can be found at www.childrens.health.qld.gov.au/referapatient