Paediatric Referral

Allied Health Intervention

BlueCare™ UnitingCare Queensland

phn BRISBANE SOUTH
An Australian Government Initiative

Forward completed referral form to Blue Care *via fax 1800 170 446*

Referral To:	**Referral Date:**
Phone:	**Fax:**
Address:	
Discipline of Provider: ☐ Occupational Therapy ☐Speech Pathology ☐Physiotherapy ☐Social Work ☐Complex Podiatry ☐Dietetics	

Patient Details:	
Name:	
Address:	
Home Phone:	**Mobile:**
Email:	**Preferred contact method:**
Date of Birth:	**Gender:**
Ethnicity:	
Parent/Carer Name:	**Parent/Carer Relationship:**
Primary Language other than English:	☐ **Is an Interpreter required.**

Eligibility (provide one or more)	
☐**Health Care Card:**	☐**Centrelink Concession Card:**
☐**Family Tax Benefit:**	
Other AHP Services accessed in the last 12 months: ☐ Queensland Education ☐ Queensland Health Children's Services ☐ Better Start Initiative ☐ Other disability support service If yes, please detail type:	
Reason for referral:	
Expected Outcomes:	
☐ **This patient has a Primary Development Disorder**	
If yes, please provide details:	

Relevant History
Medical History:
Family History:
Social History:

Referrer Details	
Referrer Name:	**Phone:**
Organisation:	**Fax:**

☐ ***The Parent/Caregiver has provided consent for this referral***