POST NATAL
Contact Referral

phn BRISBANE SOUTH
An Australian Government Initiative

Affix Mother's Label here	Affix Baby's Label here

Aboriginal ☐ Torres Strait Islanders ☐ Non-Indigenous ☐ NESB: preferred language: .....

Interpreter required: ☐ Yes ☐ No

Pregnancy Details:
Gravida:..... Parity: ..... M:..... TOP:..... NND: .....

Discharge Hospital: ☐ Mater Public ☐ Redlands ☐ Greenslopes Private
☐ Mater Private ☐ Logan ☐ Sunnybank Private
☐ Other: .....

BIRTH: ☐ Vaginal ☐Assisted ☐ LUCS Perineal Sutures ☐Yes ☐No

Sex: ☐ M ☐ F DOB: ..... / ...../..... Time:..... Gestation at Birth: ..... Weeks

Birth weight:..... Feeding: ☐ Breast ☐ Formula ☐Other

Baby Discharge Date: ..... / ..... / ..... Discharge Age: ..... Discharge Weight: .....

Mothers Discharge Date: ...../..... / .....

Mother advised of referral to:
☐ GP ☐ Home visiting service ☐ Child Health ☐ ATODS ☐ Social Work
☐ Indigenous Agency ☐ Mental Health ☐ Other .....

Influencing Factors:
☐ Preterm ☐ Multiple birth ☐ Nursery Admission ☐ Congenital Condition (*please state*).....
☐ Child Protection Notification ☐ Other:..... Maternal Concerns.....

Comments

Full Name	Signature	Designation	Date

SERVICE PROVIDER REFERRAL MANAGEMENT

Date referral received: ..... / ..... / .....

Phone contact made, ☐ Y ☐ N date: ..... / ..... / .....

2nd Phone Attempt at contact ☐Y ☐ N date: ..... / ..... / ..... ☐ Client declined written advice sent

3rd Attempt letter to contact ☐Y ☐ N date: ..... / ..... / .....

Date of Consult: ☐ Home Visit ☐ Clinic Visit ☐ Phone
Date...../...../..... time .....
Date...../...../..... time .....

Full Name	Signature	Designation	Date
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Client Consent for Home Visiting

The Mums and Bubs Program is an initiative to provide enhanced maternal and child health support in the first 12 months following birth. As part of this program, you will be offered two home visits in the first month following birth if you reside in the Metro South Hospital and Health Service (MSHHS) catchment. Additionally, I consent to information regarding myself and my newborn/s from this visit to be forwarded to my doctor, specialist and/or Child Health Service.

I have been informed about the nature of the Mums and Bubs Program offered within Metro South and consent to home visits:

Name of the Client:……

of (Address) ……..

…….

Signature: ……. Date: ……/……/…….

Name of Parent/Substitute Decision Maker: ……..

Relationship of Substitute Decision Maker (if applicable): ……

Signature: ……. Date: ……/……/…….

Substitute Decision Maker: Under the Powers of Attorney Act 1998 and/or the Guardianship and Administration Act 2000. If the patient is an adult unable to give consent, an authorised decision-maker must give consent on the patient's behalf.

Name of Witness: …… Designation: ……..

Signature: ……. Date: ……/……/…….