ACT Government | Canberra Health Services

HEALTHCARE ACCESS AT SCHOOL REFERRAL

Complete details or affix label

URN: _____

Family name: _____

Given names: _____

DOB: _____ Sex: _____

Parent/Carer contact details

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Address: _____ Address: _____

_____ _____

Phone: _____ Phone: _____

☐ **Parent/Carer informed of referral** *(please tick)*

School details

School: _____ School informed of referral: ☐ Yes ☐ No

Health needs at school (procedures/tasks)

Brief relevant past medical history

Referring team: _____ Paediatrician: _____

Referrer's contact details (phone/email): _____

Referrers name:

_____

Signature Print name Designation Date

Please send this form to Healthcare Access at School:

Email: HAAS@act.gov.au **Fax:** 62051591 **Post:** GPO Box 825, Canberra City 2601