ACT Government | Canberra Health Services

SKIP REFERRAL

Email: SKIP@act.gov.au

Complete details or affix label

URN: _____

Family name: _____

Given names: _____

DOB: _____ Sex: _____

All sections require completion before the referral can be submitted.

Client Details

☐ Consent from client obtained

Given names: _____ Surname: _____

Usual address: _____

Phone Home: _____ Mobile: _____

Email address: _____

Message authorisation: ☐ Home ☐ Mobile ☐ SMS ☐ Email

Next of Kin

Name: _____ Relationship: _____

Phone Home: _____ Mobile: _____

Email address: _____

Message authorisation: ☐ Home ☐ Mobile ☐ SMS ☐ Email

Emergency Contact Details *(if different from above)*

Name: _____ Relationship: _____

Phone Home: _____ Mobile: _____

Email address: _____

Message authorisation: ☐ Home ☐ Mobile ☐ SMS ☐ Email

Demographic Details

Country of birth: _____ Maternal ethnicity: _____

Paternal ethnicity: _____ Religion: _____

Language spoken: _____ Interpreter required: ☐ Yes ☐ No

Identifies as: ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither

Living Arrangements

☐ Family - both parents

☐ Family - one parent

☐ Family - shared custody

☐ Foster

☐ Other *(specify)*: _____

Funding Type

Medicare number: _____

NDIS: ☐ Yes ☐ No ☐ Pending approval

Health Care Card: ☐ Yes ☐ No

Medical Practitioner

GP name: _____ GP Practice: _____

Phone: _____

Specialist name: _____ Specialist address: _____

Phone: _____

Are there any court orders in place: ☐ Yes ☐ No

If yes, please provide details: _____

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SKIP REFERRAL

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Other Services

Has the child been receiving and other services at the time of referral? ☐ Yes ☐ No

If yes please tick those that apply:

☐ Psychology (CHS/Private)
☐ Exercise physiologist (CHS/Private)
☐ Physiotherapy (CHS/Private)
☐ Dietitian (CHS/Private)
☐ Child and Youth Protection Services
☐ Other *(specify)*

If other, please specify:

_____

_____

Current Relevant Clinical History

BP *(if applicable)*: _____ mmHg | Heart Rate: _____ bpm | Respiratory Rate: _____ bpm

Please weigh and measure the child and enter the data below. If it is not possible to take the child's measurements, please estimate and complete the estimated data box below.

☐ Actual ☐ Estimate

*Height: _____ cm	*Weight: _____ kg	BMI: _____ %ile for age
%ile: _____	%ile: _____	
Waist circumference: _____ cm		

Child's Medical History *(tick those that apply)*

☐ Mental health
☐ Respiratory
☐ Hypertension
☐ Hypercholesterolemia
☐ None
☐ Osteoarthritis
☐ Gastrointestinal
☐ Sleep problems
☐ Genetic disorder
☐ Other *(specify)*: _____
Diabetes: ☐ IDDM ☐ NIDDM
☐ Insulin resistance
☐ Dental
☐ Acanthosis Nigricans

If yes, please provide details:

_____

_____

Allergies: _____

Medications: _____

Social details: _____

School and year group: _____

Are there any concerns with school attendance: ☐ Yes ☐ No

If yes, please provide details: _____

Anything else that we should know:

_____

_____

_____

Family Medical History *(tick those that apply)*

☐ Heart disease
☐ Weight concerns
☐ PCOS
☐ Other *(specify)*: _____
☐ Insulin resistance

If yes, please provide details:

_____

_____

_____

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Email: SKIP@act.gov.au

Complete details or affix label

URN: _____

Family name: _____

Given names: _____

DOB: _____ Sex: _____

Investigations

Has the child had any recent blood tests: ☐ Yes ☐ No

Has the child had any other medical investigations? ☐ Yes ☐ No

If yes please list and attach results if available:

_____

_____

Interventions

What suggestions/interventions have been made or tried so far:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Comments

Any additional comments:

_____

_____

_____

_____

Referrers Details - CHS Staff *(please print clearly)*

_____

Clinician name | CHS Service | Designation | Date

External Referrers *(please print clearly)*

Referring clinician: _____

Practice name: _____ Phone/mobile: _____

Address: _____ Fax number: _____

Email: _____ Date:

If you answered yes to any recent blood tests or current court orders or NDIS plans please include a copy with the referral email. On completion of the SKIP Patient Information and Referral please email to SKIP@act.gov.au

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