REFERRAL FORM

GIPPSLAND SLEEP & SETTLING PROGRAM

Date Completed: _____

The Queen Elizabeth Centre (QEC) is Victoria's largest Early Parenting Centre.

Our **Vision** is for children to get the best start in life.

We provide advice and a range of programs aimed at supporting parents in their parenting journey.

☑ Is your client a parent/carer of a child between the age of 6 weeks and under 2 years?

☑ Is your client experiencing challenges in relation to your child's sleep and settling?

☑ Is your client seeking information and support in addressing these concerns?

If so, QEC may be able to help.

To ensure that we can provide your client with timely and appropriate help could you please complete all sections of this referral form and return to QEC.

This referral form is to be completed by Health Professionals. We strongly recommend that the parent/carer being referred to QEC is involved in the completion to this form.

Health Professional, please provide the following:

Name	
Professional Role	
Email	
Phone Number	

Please describe your reason for contacting QEC:

QEC is committed to protecting your privacy. Information provided in this form will be kept confidential and used only to support your needs.

ADMINISTRATION USE ONLY

UR No.: _____

Details of family members:

	Primary Carer	Secondary Carer (Partner)	Child/ren this referral relates to	
			Child 1	Child 2 (*if applicable*)
First Name				
Surname				
DOB				
Medicare Details	**Number:** _ _ _ _-_ _ _ _ _-_ **Ref no:** _____ **Expiry:** ____ / ____	**Number:** **(if different from Primary Carer)** _ _ _ _-_ _ _ _ _-_ **Ref no:** _____ **Expiry:** ____ / ____	**Number:** **(if different from Primary Carer)** _ _ _ _-_ _ _ _ _-_ **Ref no:** _____ **Expiry:** ____ / ____	**Number:** **(if different from Primary Carer)** _ _ _ _-_ _ _ _ _-_ **Ref no:** _____ **Expiry:** ____ / ____
Do you have a Healthcare Card?	☐ Yes ☐ No	☐ Yes ☐ No		
Address				
Contact Number			N/A	N/A
Email			N/A	N/A
Gender	☐ M ☐ F ☐ Other	☐ M ☐ F ☐ Other	☐ M ☐ F ☐ Other	☐ M ☐ F ☐ Other
Marital Status	☐ Single ☐ Married ☐ Defacto ☐ Separated	☐ Single ☐ Married ☐ Defacto ☐ Separated	N/A	N/A
Country of Birth				
Year of arrival **(if not born in Australia)**				
Do you need an Interpreter?	☐ Yes ☐ No	**If Yes, please specify what language:**		
Aboriginal	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Torres Strait Islander	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Please provide details of any of the following services you are engaged with:

Service	Name	Phone No.	Address
GP			
Maternal & Child Health			
Other (e.g. paediatrician, psychologist, psychiatrist)			
Other			

ADMINISTRATION USE ONLY

UR No.: _____

HISTORY: Please complete the following:

	Primary Carer	**Secondary Carer (Partner)**	**Child/ren this referral relates to**	
			Child 1	**Child 2** (*if applicable*)
Allergies Details	☐ Yes ☐ No If Yes _____	☐ Yes ☐ No If Yes _____	☐ Yes ☐ No If Yes _____	☐ Yes ☐ No If Yes _____
Special dietary requirements?	☐ Yes ☐ No Details: _____	☐ Yes ☐ No Details: _____	☐ Yes ☐ No Details: _____	☐ Yes ☐ No Details: _____
Anxiety	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Attachment/bonding concerns	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Behavioural concerns	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Intellectual disability	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Learning difficulty	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Physical disability	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Post-natal depression	☐ Yes ☐ No	☐ Yes ☐ No	N/A	N/A
Psychiatric illness	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Sleep issues	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Any other medical condition Details:	☐ Yes ☐ No If Yes _____	☐ Yes ☐ No If Yes _____	☐ Yes ☐ No If Yes _____	☐ Yes ☐ No If Yes _____

Child details	
Gestational age at birth (number of weeks)	
Baby weight at birth in grams	
Child's current weight in grams	
Your child's development for his/her age is	☐ Good ☐ Average ☐ Poor
Additional Child (*if applicable*)	
Gestational age at birth (number of weeks)	
Baby weight at birth in grams	
Child's current weight in grams	
Your child's development for his/her age is	☐ Good ☐ Average ☐ Poor

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Parent/Primary Carer	
Your general health	☐ Good ☐ Average ☐ Poor
Are you taking any medication?	☐ Yes ☐ No *If yes, please list here*:
Is the Child on any medication?	☐ Yes ☐ No *If yes, please list here*:
How often do you have an alcoholic drink of any kind?	☐ Every day ☐ 5-6 days/week ☐ 3-4 days/week ☐ 1-2 days/week ☐ 2-3 times/month ☐about 1 day/month ☐ less often ☐ Never
Are you a smoker?	☐ Yes ☐ No
How would you describe the current level of support you receive from your partner?	☐ High ☐ Average ☐ Low
How would you describe the current level of support you receive from family and/or friends?	☐ High ☐ Average ☐ Low
How happy are you with your parenting role?	☐ Happy ☐ Unsure ☐ Unhappy
How would you rate your relationship with your child?	☐ Good ☐ Unsure ☐ Poor
Have you experienced family violence?	☐ Yes ☐ No
Are you in anyway worried about the safety of yourself or your children?	☐ Yes ☐ No

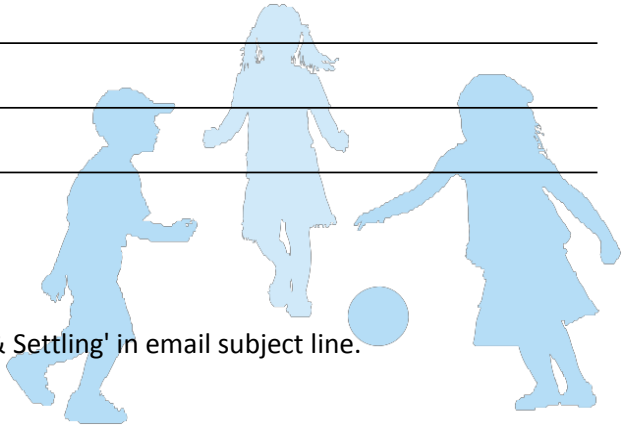
Please provide any other relevant information:

_____

_____

_____

_____



Thank you for completing this referral.

Please return your referral to QEC via email:

To: theqec@qec.org.au with 'Referral Gippsland Sleep & Settling' in email subject line.

ADMINISTRATION USE ONLY			
Date Received		**UR No.**	
Phone Call:	☐ Completed Date: _____	☐ Attempted – Unsuccessful Date: _____ Date: _____ Date: _____ Date: _____ Date: _____	☐ Scheduled for later: Day:_____ AM/PM:_____
Programs referred to:	☐ Residential	☐ Daystay	☐ Parenting Plus
	☐ Playsteps – Frankston	☐ Playsteps – Noble Park	☐ Education Session
	☐ Gippsland Sleep & Settling	☐ Other (please specify)	

NOTES: