



# 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:**

---

---

---

---

---

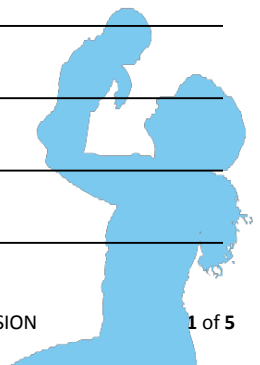
---

---

---

---

---



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)
<b>First Name</b>				
<b>Surname</b>				
<b>DOB</b>				
<b>Medicare Details</b>	<b>Number:</b> _____ <b>Ref no:</b> _____ <b>Expiry:</b> ____ / ____	<b>Number:</b> (if different from Primary Carer) _____ <b>Ref no:</b> _____ <b>Expiry:</b> ____ / ____	<b>Number:</b> (if different from Primary Carer) _____ <b>Ref no:</b> _____ <b>Expiry:</b> ____ / ____	<b>Number:</b> (if different from Primary Carer) _____ <b>Ref no:</b> _____ <b>Expiry:</b> ____ / ____
<b>Do you have a Healthcare Card?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Address</b>				
<b>Contact Number</b>			N/A	N/A
<b>Email</b>			N/A	N/A
<b>Gender</b>	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other
<b>Marital Status</b>	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Defacto <input type="checkbox"/> Separated	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Defacto <input type="checkbox"/> Separated	N/A	N/A
<b>Country of Birth</b>				
<b>Year of arrival</b> (if not born in Australia)				
<b>Do you need an Interpreter?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If Yes, please specify what language:</b>		
<b>Aboriginal</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Torres Strait Islander</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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			

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	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes _____	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes _____	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes _____	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes _____
Special dietary requirements?	<input type="checkbox"/> Yes <input type="checkbox"/> No Details: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Details: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Details: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Details: _____
Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Attachment/bonding concerns	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Behavioural concerns	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Intellectual disability	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Learning difficulty	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Physical disability	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Post-natal depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	N/A	N/A
Psychiatric illness	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sleep issues	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any other medical condition  Details:	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes _____	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes _____	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes _____	<input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Good <input type="checkbox"/> Average <input type="checkbox"/> Poor
<b>Additional Child (if applicable)</b>	
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	<input type="checkbox"/> Good <input type="checkbox"/> Average <input type="checkbox"/> Poor

**ADMINISTRATION USE ONLY**

UR No.: \_\_\_\_\_

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

Please provide any other relevant information:

---



---



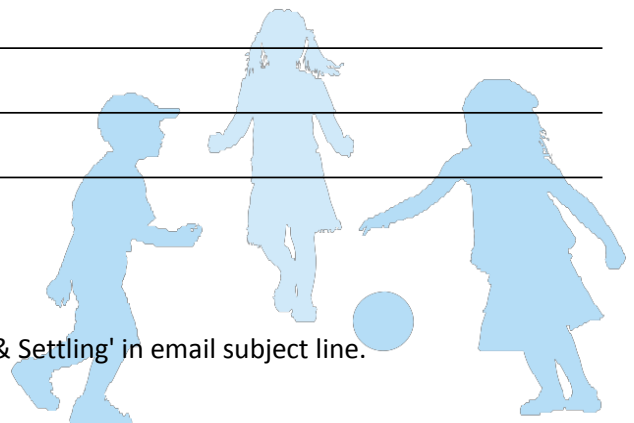
---



---

Thank you for completing this referral.

Please return your referral to QEC via email:

To: [theqec@qec.org.au](mailto:theqec@qec.org.au) with 'Referral Gippsland Sleep & Settling' in email subject line.

ADMINISTRATION USE ONLY

Date Received		UR No.	
Phone Call:	<input type="checkbox"/> Completed  Date: _____	<input type="checkbox"/> Attempted – Unsuccessful  Date: _____ Date: _____ Date: _____ Date: _____ Date: _____	<input type="checkbox"/> Scheduled for later: Day: _____ AM/PM: _____
Programs referred to:	<input type="checkbox"/> Residential	<input type="checkbox"/> Daystay	<input type="checkbox"/> Parenting Plus
	<input type="checkbox"/> Playsteps – Frankston	<input type="checkbox"/> Playsteps – Noble Park	<input type="checkbox"/> Education Session
	<input type="checkbox"/> Gippsland Sleep & Settling	<input type="checkbox"/> Other (please specify)	

**NOTES:**

This image shows a single sheet of white paper with horizontal blue ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.