

REFERRAL FORM



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.

- Are you a parent/carer of a child between the age of 6 weeks and under 4 years?
- Are you experiencing challenges in relation to your child’s sleep and/or behaviour?
- Are you seeking information and support in addressing these concerns?

If so QEC may be able to help you.

To ensure that we can provide you with timely and appropriate help could you please complete this referral form and return to QEC. Once QEC has received your completed Referral Form, you will receive a phone call from one of our Assessment and Intake (A&I) clinicians within one working week

Note that QEC Assessment and Intake hours are **8.30am to 4.00pm Monday –Friday** (closed on public holidays)

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

This form has been completed by: Self Health Professional (*please tick*)

If Health Professional, please provide the following:

Name	
Professional Role	
Email	
Phone Number	

Please describe your reason for contacting QEC:



Private & Confidential

QEC is committed to protect your privacy. Please note that 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	Additional Child Under 4 years old (if applicable)
First Name				
Surname				
DOB				
Address				
Contact Number			N/A	N/A
Email			N/A	N/A
Gender	<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
Marital Status	<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
Country of Birth				
If born overseas what year did you arrive in Australia				
Do you need an Interpreter?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, please specify what language:		
Aboriginal	<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
Torres Strait Islander	<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

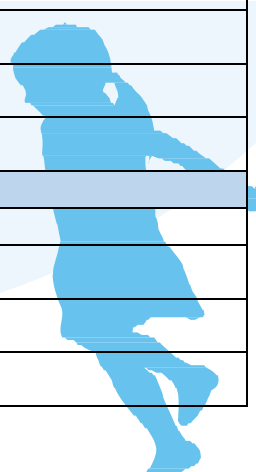
Please provide details of any of the following services you are engaged with:

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

HISTORY: Please complete the following:

	Parent/ Primary Carer	Secondary Carer (Partner)	Child/ren this referral relates to	
			Child	Additional Child Under 4 years old (if applicable)
Allergies Details	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
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	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

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
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	<input type="checkbox"/> Good <input type="checkbox"/> Average <input type="checkbox"/> Poor

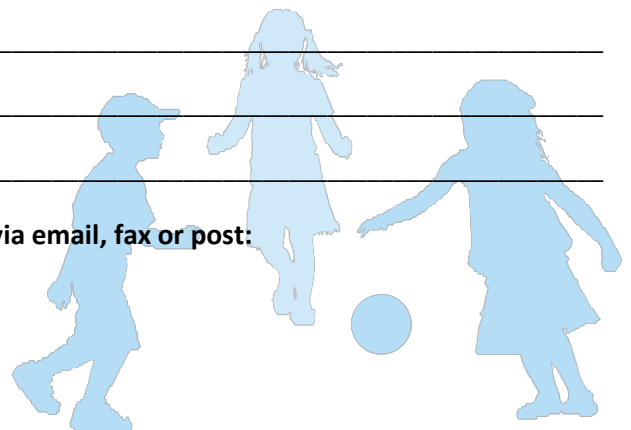


Parent/Primary Carer	
Your general health	<input type="checkbox"/> Good <input type="checkbox"/> Average <input type="checkbox"/> Poor
Are you taking any medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please list here:</i>
Is the Child on any medication?	<input type="checkbox"/> 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 via email, fax or post:

Email to: gecai@qec.org.au
Fax: 03 9549 2779
Mail: 53 Thomas St, Noble Park, VIC 3174



Once we receive your completed form, it will be reviewed by our Assessment & Intake Team and you will then receive a phone call within a week (**Mon-Fri from 8.30am -4.00pm**). Please allow 15 minutes for the call.

