Private & Confidential

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 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.

Details of person completing this form: ____

If not the parent, please provide contact details: ____

Please describe your reason for contacting QEC:

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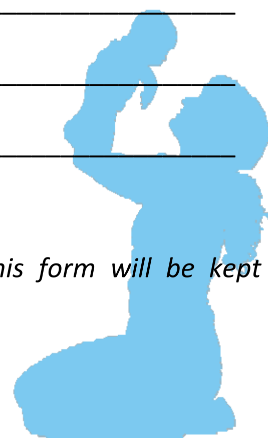

QEC is committed to protect your privacy. Please note that information provided in this form will be kept confidential and used only to support your needs.

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Details of family members:

	Primary Carer	Secondary Carer (Partner)	Child/ren this referral relates to	
			Child	Additional Child (*if applicable*)
First Name				
Surname				
DOB				
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				
If born overseas what year did you arrive 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			

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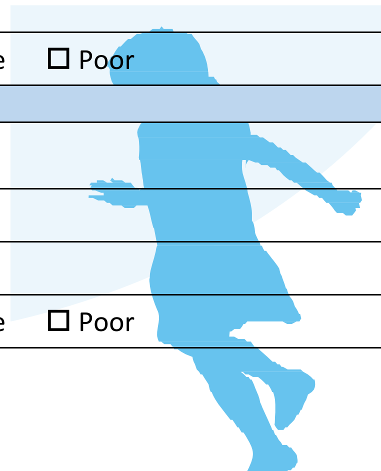
HISTORY: Please complete the following:

	Parent/ Primary Carer	Secondary Carer (Partner)	Child/ren this referral relates to	
			Child	Additional Child (*if applicable*)
Allergies Details	☐ Yes ☐ No If Yes ___________________	☐ Yes ☐ No	☐ Yes ☐ No If Yes ________________	☐ Yes ☐ No
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	☐ Yes ☐ No If Yes __________________	☐ Yes ☐ 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	☐ Good ☐ Average ☐ Poor
Additional Child (*if applicable*)	
Gestational age at birth)	
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*:
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
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:

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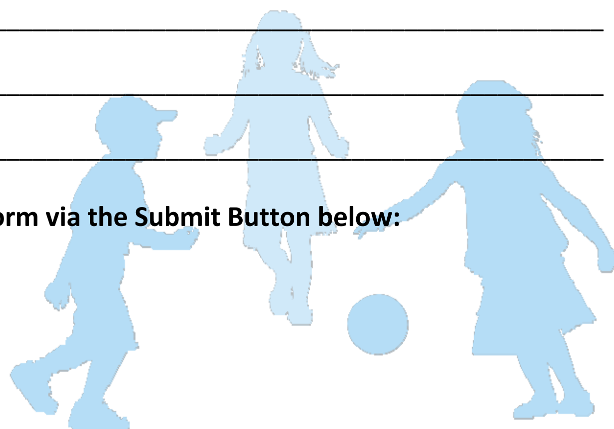
Thank you for completing this referral. Please return your referral form via the Submit Button below:



NOTE: If you are having difficulty submitting this form, please download it to your computer, complete and email the form to QEC at: *qecai@qec.org.au*

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.

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ADMINISTRATION USE ONLY			
Date Received			
Phone Call:	☐ Completed Date: ________________ Duration: _____________	☐ Attempted – Unsuccessful Date: ________________	☐ Scheduled for later: Day:_________________ AM/PM:______________
Programs referred to:	☐ Residential	☐ Daystay	☐ Parenting Plus
	☐ Playsteps – Frankston	☐ Playsteps – Noble Park	☐ Education Session
	☐ Other (please specify)		

NOTES:

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