HUNTER NEW ENGLAND LOCAL HEALTH DISTRICT

Facility: _____

BIRRA-LI REFERRAL FORM

Phone: 4016 4900 **Fax:** 4016 4945

Email: HNELHD-Birrali@health.nsw.gov.au

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. ___/___/___	M.O.
ADDRESS	
LOCATION / WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

JHH155

HNE281626

BINDING MARGIN – DO NOT WRITE

BIRRA-LI REFERRAL FORM

Referral Source – Name: _____ **Date:** ___/___/___

Address: _____ **Phone:** _____

Referral criteria: *Indigenous women or Non –Indigenous women with an Indigenous partner who is pregnant or has Indigenous children aged < 5 years in the Newcastle, Lake Macquarie and Port Stephens Local Government Area.*

Referral To: ☐ **C&FH** ☐ **AMIHS** ☐ **Breastfeeding** ☐ **Social Work** ☐ **Cultural Support**

Mother / Carer Name: _____ **Indigenous** ☐ Y ☐ N

MRN _____ **D.O.B** _____ **Does client consent to referral** ☐ Y ☐ N

Address _____

Current mobile number: _____ **Current home ph:** _____

Best Alternate Contact No. / Email: _____

Partner Name _____ **Indigenous** ☐ Y ☐ N

D.O.B _____

Pregnant: ☐ Y ☐ N **EDD:** _____ **Gravida:** _____

Para: _____

Ultra Sound attended: ☐ Y ☐ N **Where:** _____

Initial Bloods attended: ☐ Y ☐ N **Where:** _____

Is she a current CFH client: ☐ Y ☐ N **Is the Child'ren OOHC:** ☐ Y ☐ N *(PTO to add more information)*

Child or Children for Child and Family Health Referral:

Name (including surname)	MRN	DOB	Comments/issues	Gest.	Birth wt	Sex	Feeding

Reason for Referral: *If any is ticked - further information is required (PTO to add further information)*

Domestic Violence		**Housing**		**Parenting**		**Young Parent**	
Drug & Alcohol		**Mental Health**		**Financial**		**Breastfeeding Issues**	
Relationship		**Child Protection**		**Q4NL**		**Other**	

Comments/Client expectations: *PTO to add further comments*

_____

_____

_____

Other agencies involved:

_____

_____

130619

(office use) Service requested: BSTP LMND BSF AMIHS

Correspondence

HUNTER NEW ENGLAND LOCAL HEALTH DISTRICT

Facility: _____

CHILD AND FAMILY HEALTH CLINICAL/CULTURAL HANDOVER

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. ____/____/____	M.O.
ADDRESS	
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

HNE281626

Keep information concise and relevant, to coincide with verbal handover

Any Pregnancy, Birth, Breastfeeding or Postnatal concerns:

Is Child in OOHC (Out of Home Care): ☐ Y ☐ N *(if so provide details)*

Siblings: Are they current CFH Clients: ☐ Y ☐ N **Are they Indigenous:** ☐ Y ☐ N

Family Supports/who are they/their Mob/Community:

Psychosocial concerns: *(eg: housing, mental health, relationships, DV, D&A, EPDS)*

Parenting Capacity concerns & strengths: *(including any concerns regarding FOB/partner)*

Other Services in place: *(eg: social worker, agencies, FACS, Family Services, IFBS, Brighter Futures)*

BINDING MARGIN – DO NOT WRITE

NB: If referral to Social Worker is ONLY for the following: Housing, Centrelink, Family dispute, Custody, Legal issues or referral to other agencies. Please offer Client FAMILY REFERRAL SERVICE details 1300 006 480