



FAMILY NAME

MRN

GIVEN NAME

MALE  FEMALE

Facility: **St George Hospital and  
The Sutherland Hospital**

D.O.B. \_\_\_\_ / \_\_\_\_ / \_\_\_\_

M.O.

ADDRESS

**FAMILY CARE  
COTTAGE REFERRAL**

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Referral Agent Details- please complete and / or add practice stamp below

Name of Referrer		Date	
Profession		Agency	
Address			
Email			
Phone number	Office	Mobile	Fax
Best time to contact you for further information		Preferred contact method	

Discussion about referral with parent  Parent agrees with referral

Date of last Child and Family Health appointment \_\_\_\_\_ Clinic \_\_\_\_\_

Referral Agent signature	Date
Parent Signature	Date

Further Comments

**Family Details**

	Full Name	DOB	Address	Contact Number
Parent				
Parent				

Marital Status  Married  Separated  De facto  Divorced

Primary Care Giver (if other than parent) Relationship and contact details

Aboriginal  Yes  No Torres Strait Islander  Yes  No

Does the Parent require an interpreter & if yes, what language?

Presenting Child/ren	Full Name	DOB	Gender
			<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
			<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
			<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE



SES010745

Holes Punched as per AS2828.1: 2012  
BINDING MARGIN - NO WRITING

FAMILY CARE COTTAGE REFERRAL

SES010.745



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- New Appointment  Follow up appointment (date of last visit if known) \_\_\_\_\_  
 Sleep session (Preferred session)  AM  PM

OR

Breastfeeding Clinic

BABY: FBF  EBM  Bottle Fed  Both

How much: \_\_\_\_\_ How often: \_\_\_\_\_

Settling issues: Breast fed to sleep  Catnapping  Unsettled day time  Unsettled night Time

Settling:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Feeding Issues:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Relevant Medical Conditions & Management & Medication:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Mother:

Mental Health Issues & Management:

\_\_\_\_\_

EDS Score on  / \_\_\_\_ / \_\_\_\_ Score on Question 10

Domestic Violence Screening: Attended: Yes  No

Outcomes of DV Issues:

\_\_\_\_\_  
 \_\_\_\_\_

Social Issues & Support:

Other Issues &/ or stressors:

\_\_\_\_\_

FACS involvement: Yes  No

Other agencies / services involved:

**Possum/Brighton Use only** Family Contacted Date: \_\_\_\_\_  
 Appointment date: \_\_\_\_\_  
 Attended  Cancelled  Deferred  Failed to Attend  Service attended   
 Date: \_\_\_\_\_ Possum Cottage  Brighton Cottage

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