

Maternal and Child Health Referral Form



City of Whittlesea

Tel: 9404 8888

Email: mch@whittlesea.vic.gov.au

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Referrers Details:

Name of Referrer: _____ Date of Referral: ____/____/____

Professional Role: _____

Address: _____ Post Code: _____

Telephone: _____ Fax: _____ Email: _____

Has this referral to our service been discussed with the family and do they consent to this referral? YES NO

Primary Carer:

Mother: Father: Other: _____ Telephone No: _____

Given Name: _____ Surname: _____

Address: _____

Post Code: _____ Date of Birth: ____/____/____

Language spoken: _____ Interpreter Language required: _____

Does this person identify as: Aboriginal / Torres Strait Islander? Yes: No:

Is this person an Asylum Seeker? Yes: No: Is this person a Refugee? Yes: No:

Children: (in chronological order)

Given Name: _____ Surname: _____ Male: Female:

Address: _____

Post Code: _____ Date of Birth: ____/____/____

Has this child been seen by Maternal and Child?: Yes: No: If yes, in which municipality: _____

Given Name: _____ Surname: _____ Male: Female:

Address: _____

Post Code: _____ Date of Birth: ____/____/____

Has this child been seen by Maternal and Child?: Yes: No: If yes, in which municipality: _____

Alerts: (include any worker safety issues if know, dangerous behaviour/s, pets, etc.)
