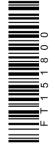




RVICE Government	lost
REFERRAL	SURNAME
Child Health and Parenting Service	NAMES
(CHaPS)	ADDRESS
STATEWIDE	
ACILITY:	

PT ID



ACILITY:	
	(Tick ☑ as appropriate, format time as 00:00 (24 hour) and date as DD/MM/YYYY)
Has the client consented for referral? (If the	answer is NO the referral cannot be accepted)
Interpreter/support service required: $\ \square$ Yes [☐ No If yes, language: ☐ Present
If patient identifies as Aboriginal or Torres Strain	it Islander – Aboriginal Health Liaison Officer present: Yes No
CLIENT INFORMATION	
Client (print name):	Client THCI:
Date of birth: DD / MM / YYYYY Age:	Gender:
Cultural identity:	Phone number:
Primary caregiver (print name):	Caregiver THCI:
Phone number:	Other phone contact:
Other caregiver (print name):	Caregiver THCI:
Phone number:	Other phone contact:
REFERRAL TO CHAPS FROM NEONAT	AL/PAEDIATRIC UNIT *complete applicable fields
Notification of: Admission - Admission da	ate: DD/MM/YYYY Discharge - Discharge date: DD/MM/YYYYY
Gravity: Para:	Delivery: Gestation:
Birth weight: Apgars	•
	arge medications:
Child Safety Services involvement: Yes	
Detail any current orders, plans, and case many	anager details.
Antenatal complications:	
Reason for admission:	
Current progress:	
Complications since birth:	
Special nursing care:	
Feeding method/feeding plan on discharge:	
Post-discharge follow-up:	





REFERRAL

Child Health and Parenting Service (CHaPS)
STATEWIDE

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SURNAME	 		. 0	. D.O.	Br.L.	abel	
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ADDRESS	 						

STATEWIDE	ADDRESS
FACILITY:	
	(Tick ☑ as appropriate, format time as 00:00 (24 hour) and date as DD/MM/YYYY)
REFERRAL TO CHAPS FROM ALL OTHER S	
Antenatal referral Postnatal referral C	CHaPS program (if known): Wetaway Parenting Centre
Child Safety Services involvement: Yes	□No
Detail any current orders, plans, and case manage	er details.
Recent inpatient admission:	☐ Yes*- Length of admission
*Provide admission details including any assessm	nents/diagnoses:
*Discharge plans, including scheduled follow-up a	and referrals made:
Describe the reason for referral to CHaPS – include	ding client risks and identified needs:
Are there any other agencies/health professionals	involved in this client's care?
Describe any relevant medical history:	
REFERRER DETAILS	
Referral from: (print service/department):	
Referrer (print name):	
Date of referral: DD / MM / YYYYY	Phone number:
Email:	
Signature:	Designation:
	@ths.tas.gov.au For enquiries call 1300 064 544