TASMANIAN HEALTH SERVICE

Tasmanian Government

REFERRAL

Child Health and Parenting Service (CHaPS)

STATEWIDE

FACILITY: _____

PT ID									

SURNAME..... D.O.B .....

OTHER NAMES.....

ADDRESS .....

.....

Attach Patient Sticker Label

(Tick ☑ as appropriate, format time as 00:00 (24 hour) and date as DD/MM/YYYY)

FT1151800

Has the client consented for referral? **(If the answer is NO the referral cannot be accepted)** ☐ Yes ☐ No

Interpreter/support service required: ☐ Yes ☐ No If yes, language: _____ ☐ Present

If patient identifies as Aboriginal or Torres Strait Islander – Aboriginal Health Liaison Officer present: ☐ Yes ☐ No

CLIENT INFORMATION

Client *(print name)*: Client THCI:

Date of birth: DD / MM / YYYY 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 NEONATAL/PAEDIATRIC UNIT** **complete applicable fields*

Notification of: ☐ Admission - Admission date: DD/MM/YYYY ☐ Discharge - Discharge date: DD/MM/YYYY

Gravity: Para: Delivery: Gestation:

Birth weight: Apgars: Expected length of stay:

Discharge weight: Discharge medications:

Child Safety Services involvement: ☐ Yes ☐ No

Detail any current orders, plans, and case manager details.

Antenatal complications:

Reason for admission:

Current progress:

Complications since birth:

Special nursing care:

Feeding method/feeding plan on discharge:

Post-discharge follow-up:

Social history *(include any social complications noted on admission, risks/behaviour problems, referrals for social supports)*:

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☐ **REFERRAL TO CHaPS FROM ALL OTHER SERVICES** **complete applicable fields*
☐ Antenatal referral ☐ Postnatal referral CHaPS program *(if known)*: ☐ Wetaway ☐ Parenting Centre
Child Safety Services involvement: ☐ Yes ☐ No
Detail any current orders, plans, and case manager details.
Recent inpatient admission: ☐ No ☐ Yes*- Length of admission
*Provide admission details including any assessments/diagnoses:
*Discharge plans, including scheduled follow-up and referrals made:
Describe the reason for referral to CHaPS – including 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 / YYYY Phone number:
Email:
Signature: Designation:
EMAIL REFERRAL TO: chaps.referral@ths.tas.gov.au For enquiries call 1300 064 544

CHAPS REFERRAL