NSW GOVERNMENT Health

The Sydney children's Hospitals Network
care, advocacy, research, education

Psychological Medicine
DRAFT SCHN MHID Hub Referral Form
the children's hospital at Westmead

Eligibility:
☐Diagnosis of intellectual disability and/or autism spectrum disorder.
☐Existing psychiatrist or paediatrician providing ongoing care. If both, psychiatrist referral is preferred. GP or self-referrals cannot be accepted.
☐Referral to local community mental health services attempted.
☐Engaged with local disability services e.g. (NDIS) funded positive behaviour support.

Age limit for new referrals is up to the age of 18 years. **SCHN Hub Phone: 9845 2005 / Fax: 9845 2009**
SCHN-CHW-PsychmedIntake@health.nsw.gov.au
Referral to : Dr David Dossetor and delegates

SCHN MHID HUB REGISTRATION AND REFERRAL

Referrer Details

Name of referrer:	Provider Number:
Professional discipline:	
Referrer email address:	Phone:
Referrer organisation:	LHD:
Will you provide ongoing clinical care for this patient?	

Patient Details

Title:	Given Name/s:		Surname:
Preferred Name:		DOB:	Gender: ☐male ☐other ☐female
Mailing Address:		Parent consent for referral given:	☐yes ☐no
Medicare No:			Expiry date:
Living situation	☐ with family	Out of Home Care ☐ kinship care ☐ with foster family ☐ alternative care accommodation	
Who has parental responsibility for the child?		☐ parents	☐ Minister
Country of origin		Cultural background	Religion:
Aboriginal / TSI Status:	☐ Aboriginal origin ☐ Torres Strait Islander origin		☐ neither ☐ not stated

Patient Diagnoses

Diagnosed developmental disabilities:	☐ intellectual disability ☐ mild ☐ moderate ☐ severe ☐ profound	☐ ASD ☐ Level 1 ☐ Level 2 ☐ Level 3	☐ ADHD ☐ Tic disorder ☐ FASD ☐ learning disability ☐ language disorder Other:
Previous or current diagnosed mental health conditions	☐ severe challenging behaviour ☐ anxiety disorders ☐ obsessive compulsive disorder ☐ depressive disorders ☐ bipolar disorders	☐ ODD ☐ conduct disorder ☐ psychotic disorder ☐ eating disorder ☐ dissociative disorders	☐ catatonia ☐ early onset dementia ☐ gender dysphoria ☐ post-traumatic stress disorder ☐ alcohol and/or substance use Other:
Risk Assessment/ Risk Factors:	☐ self-injurious behaviour ☐ deliberate self-harm ☐ aggression/violence ☐ risk of absconding	☐ trauma background ☐ suicide ideation ☐ child protection ☐ inappropriate sexual behaviour	☐ accommodation breakdown ☐ school non-attendance ☐ medication non-compliance Other:
Child's communication:	☐ verbal ☐ limited verbal		☐ non-verbal ☐ with assisted aids

Referral Details

Reason for referral:			
Goal of referral:	☐ medication advice ☐ advice on challenging behaviour	☐ allied health input ☐ MDT review	☐ 2nd opinion on diagnosis Other:

1010

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

Type of service preferred:	☐ joint consultation (hub, patient, family and referrer) ☐ consultation (hub, patient and family) ☐ case discussion (hub and referrer) ☐ advice (hub and referrer) ☐ any of the above	**The team will decide what service is offered depending on capacity and need**
CAMHS referral	Has a referral to CAMHS/CYMHS or relevant local community mental health service been attempted for this patient?: (NSW Mental Health Line ph: 1800 011 511)	☐ yes ☐ no
	If yes, please list outcome and reasons:	Name of service

Family Carer, Person Responsible or Guardian

Contact 1:	Name:		Phone:
	Mailing address (if different to child's):		Relationship to Child:
	Email:		
Preferred Language:		Interpreter Required:	☐ yes ☐ no
Contact 2:	Name:		Phone:
	Mailing address (if different to child's or contact 1):		Relationship to Child:
	Email Address:		
Are there any family law court orders?	☐ yes ☐ no		

Support Services

NDIS:	☐ Yes ☐ No ☐ in progress		NDIS no:
School details:	Name:	☐ mainstream school ☐ special school or SSP	☐ mainstream class ☐ support class
GP name:		Paediatrician name:	

Are any of the following services involved?	☐ occupational therapy ☐ speech therapy ☐ psychology ☐ social work	☐ behaviour support ☐ support worker/s ☐ dietician ☐ respite	☐ NDIS support coordinator ☐ NDIS local area coordinator ☐ early childhood coordinator Other:
CAMHS involvement? ☐ yes ☐ no		If yes, name of service:	

Attachments and Signature

Attachments: ☐ typewritten referral letter/information report outlining: - presenting problems - past interventions and outcomes - current and past medication/s - developmental history - family background including medical and mental health	☐ psychological or educational ☐ assessment / behaviour support plan ☐ OT and/or speech therapy reports ☐ medical reports ☐ MHOAT Mental Health Assessment ☐ NDIS plan
Print name	**Designation**
e-Signature:	**Date:**

Click to email SCHN-CHW-PsychmedIntake@health.nsw.gov.au

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1010