Dr Jane Ho, Staff Specialist

MRN _____

NAME _____

DOB _____ SEX _____

(PLEASE FILL IN **OR** AFFIX CHW PATIENT LABEL IN THIS BOX)

For CHW/SCHN Powerchart users, please complete Trapeze referral in PowerChart

Date of Referral:	**Referrer Name:**
Role of Referrer:	**Department Name:**
Consultant Name:	**Contact Number:** **Email :**

Source of Referral CHW ☐ SCH ☐ Community ☐ Self ☐

CONTACT DETAILS

Young Person Phone:	**Young Person Email:**
Parent Surname:	**Parent First name:**
Relationship to young person:	**Parent Phone:**
Address:	**Email:**

Non-English Speaking Background ☐	**Interpreter required:** □Yes □ No **Language:**
Intellectual capacity of young person: Normal ☐ Delayed ☐ Non-verbal ☐	

Medical Information

Primary diagnosis	**Co-morbidities:**

Reason for Referral to Trapeze & Priorities for Management:

Complex Medical Issues ☐ Complex Psychosocial Issues ☐ Self-Management☐ Transition planning and support ☐	Other (Please state) _____

Key Professionals

Name	Speciality
GP	

Other services involved e.g. FACS

_____

Home visit alerts e.g. AVO, risk or danger to staff

_____

Current plans for transition (i.e. where, who, when?)

_____

Have you discussed this referral with the young person/or guardian? ☐ Yes ☐ No

Next planned appointment: _____

INCOMPLETE FORMS WILL BE RETURNED TO REFERRER AND REFERAL WILL NOT BE ACCEPTED

PLEASE RETURN TO: Email: trapeze.schn@health.nsw.gov.au; Fax: 02 9382 5680

Postal Address: Trapeze, Sydney Children's Hospital, Randwick, Centre for Adolescent and Young Adult Health, Level 7, The Bright Alliance, Corner of High and Avoca Street, Randwick, NSW 2031. Phone: 02 9382 5457