

FAMILY NAME		MRN
GIVEN NAME		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
D.O.B ____ / ____ / ____		M.O.
ADDRESS		
LOCATION / WARD		
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE		

Facility: SCHN

## Trapeze referral form

Dr Jane Ho, Staff Specialist

For SCHN PowerChart users, please complete Trapeze referral in PowerChart

Does the patient meet the Trapeze referral criteria? (Patient must meet all 3 criteria)

- Aged between 14 and 25 years old, **AND**
- Complex chronic illness currently treated at SCHN, **AND**
- Unclear health transfer pathway

**Referrer contact details:**

Referrer name:
Referrer contact number:
Referrer email:
Referral date:
Referrer provider number:

Source of Referral    CHW     SCH     Community     Self     LHD

**Patient contact details:**

Patient phone:	Patient email:
Carer surname:	Carer first name:
Relationship to young person:	Carer phone:
Address:	Email:

Have you discussed transition with the patient/parent and/or guardian? Yes/No

Is the patient aware of this referral? Yes/No

When is the patient's last paediatric appointment planned for? \_\_\_\_\_ MM/YYYY

(Please note: We suggest adult referrals be sent at least 6 months before the age of 18 years of age for a smooth transition to occur)

I would like this patient to have:

- General education about transition
- Education to enhance independence and self-management
- Coordination for transfer
- Clinical collaboration with Trapeze attendance at my specialty clinic
- Other \_\_\_\_\_

**Medical history**

Chronic health condition:

\_\_\_\_\_

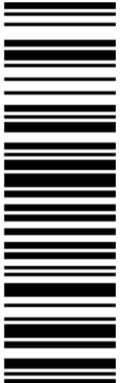
\_\_\_\_\_

Co-morbidities/other relevant information:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



Holes Punched as per AS2828.1:2019  
BINDING MARGIN - NO WRITING

TRAPEZE REFERRAL FORM

SCN010.180

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**Other Teams/Clinicians involved in care (including allied health and external providers):**

Name	Role	Contact details

Is this patient on any medications that require special approval for use or dispensing by SCHN pharmacy? Yes/No

If yes, please list

**Psychosocial**

Have you undertaken a HEEADSSS assessment? Yes/No      Date of assessment: \_\_\_\_\_

If yes, were there any areas for concern?

Is there a social worker or psychologist currently involved with the patient? Yes/No

Name/Contact: \_\_\_\_\_

**Does this patient identify as a priority population?**

- Identifies as an Aboriginal or Torres Strait Islander person
- Low income family
- Lives with a disability
- CALD background
- Refugee or asylum seeker
- Rural and remote
- Living in out of home care

**Concerns for patient during and after transition:**

- Disengagement
- Falling through the gaps
- Difficulty navigating adult health system
- Poor adherence
- Other \_\_\_\_\_

**Any other relevant information**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**INCOMPLETE FORMS WILL BE RETURNED TO REFERRER AND REFERRAL WILL NOT BE ACCEPTED.**

**PLEASE RETURN TO:** Phone: 02 9382 5457 OR Fax: 02 9382 5680

Email: [trapeze.schn@health.nsw.gov.au](mailto:trapeze.schn@health.nsw.gov.au); 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.

TRAPEZE REFERRAL FORM

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