trapeze
a supported leap into adult health

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

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ 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

SCHN – 09/2021

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 REFERAL WILL NOT BE ACCEPTED.
PLEASE RETURN TO: Phone: 02 9382 5457 OR Fax: 02 9382 5680
Email: 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.

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