|  |  |
| --- | --- |
| \*\* \*\*ACT HealthEmail: SKIP@act.gov.auFax: 6205 1198 | Affix patient label**URN:**      **Surname:**      **Given name(s):**      **Date of Birth:**      **Gender:**  |

|  |  |
| --- | --- |
| Given names:       | Surname:       |
| Usual address:       |
| **Next of Kin** |
| Name:      Relationship:      Phone: Home:      Mobile:      **Message authorisation:** [ ]  Home [ ]  Mobile [ ]  SMS |
| Name:      Relationship:      Phone: Home:      Mobile:      **Message authorisation:** [ ]  Home [ ]  Mobile [ ]  SMS |
| **Demographic Details** |
| Country of birth:       Interpreter:  Language spoken:      Identifies as:  |
| **Living Arrangements** If other, please specify:       | **Funding Type (if applicable)**Medicare number:      [ ]  Health Care Card |
| **Accommodation Setting** |
| If other, please specify:       |
| **Medical Practioner** |
| GP name:      Phone:      Specialist name:      Phone:       |
| Alerts / Allergies:      | Other Alerts: (Behavioural, Environmental)      |
|  | **Services Requested** | **Clinical Reason for Service** |
| 1. |       |       |
| 2. |       |       |
| 3. |       |       |
| Consent from consumer obtained?  |
| **Current Clinical History** |
|      Blood Pressure:      Medications:       | Height:      cm     %ileWeight:       Kg     %ileBMI:     %ile for age:    Waist circumference:      cm  |
| **Past Medical History** |
|       |
| **Social Details** |
|       |
| **Other Services** |
| **Has the child been referred to other services?** If Yes please list |
| **Other Service** | **Agency** |
|       |       |
|       |       |
| **Investigations** |
| **Has the child had any medical investigations?** If Yes please list / attach |
|       |
|       |
|       |
| **Referrers Details**  |
| Referral agency:      Contact name:      Phone/Mobile:      Fax:      Email:       |
| Delegation:       | Date:       |
| Print name:      |
| Signature:  |