Waikato District Health Board

Child Development Centre Referral

Date of Referral: ______________________ NHI (if known): ______________________

Child's Name: ____

DOB: ______________________ Country of Birth: ______________________

Sex: Male / Female Ethnicity: ______________________

Name of Parent/Caregiver: ____

Relationship to the Child: ____

Address: ____

____

Phone:(day) ______________ (night) ______________ (mobile) ______________

Need an Interpreter? Yes/No

If yes what Language? ______________________

Has this child previously attended CDC? Yes/No

Does the child's family understand **WHY** they are being referred? Yes/No

Does the family **CONSENT** to this referral? Yes/No

Will you assist the family to attend? Yes/No
(We can send you a copy of the appointment)

Why are you referring this child?

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Please attach other relevant information: (e.g. current problems, social and family issues, developmental history, past medical history and medication, school information). Include any previous assessment reports.

Are there any other services involved with this child/family now or in the past?

- ☐ Child Mental Health Services (please specify) ____________________
- ☐ Educational supports
- ☐ Disability support services
- ☐ Child and family community-based services
- ☐ Hospital-based services
- ☐ Child Youth & Family
- ☐ ACC
- ☐ Other (please specify) ____________________

Please specify if you have referred this child anywhere else?: ____________________

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Please indicate if you are requesting a particular CDC Service - e.g. Paediatrician, IDA.

____

Referred by: ____________________ Title/Agency: ____________________

Address: ____________________

Fax No: ____________________ Phone No: ____________________

Signature: ____________________ Date: ____________________

Post/Fax to:

Referral Co-Ordination Centre

Waikato Hospital
Private Bag 3200
Hamilton 3240
Fax: 07 839 8817