Dr Andrew Parkin

Child & Adolescent Psychiatrist

CONFIDENTIAL

Please complete details below that you feel comfortable giving

Details of the referred child or young person

Full name: ____

Preferred / other names known by: ____

Ethnicity: ____________________ Medicare number: __________ ____________ ___ # ___

Date of Birth: ____________________ Phone number (if appropriate): ______________________

Email address(es) (if appropriate): ____

Address: ____

____

Parent(s) or caregivers' details (room for more family details on next two pages)

There's room for a second or more parents' name and details on the next page (please also include any parents not living with their child on the next page)

Primary contact person's name____

Relationship to patient: ____

Address (if different): ____

____

Is the referred child living with you? Yes/No/part time ______________________________

Occupation: ____ Age: ____________

Email address(es): ____

Phone numbers: (H) ____________________ (M) ________________ (W) ________________

What is your preferred contact number? (Please circle): *Home* *Mobile* *Work*

Can we leave a message at these numbers? (Please circle): *Yes/No* *Yes/No* *Yes/No*

Other parents/carers continues on page 2

Other parents / carers' contact details (if applicable):

Name: ____________________

Relationship to patient: ____________ Is s/he living with you? Yes/No/part time

Address (if different): ____________________

____

Occupation: ____________________ Age: ________

Email address(es): ____________________

Phone numbers: (H) ____________ (M) ____________ (W) ____________

What is your preferred contact number? (Please circle): *Home* *Mobile* *Work*

Can we leave a message at these numbers? (Please circle): *Yes/No* *Yes/No* *Yes/No*

Name: ____________________

Relationship to patient: ____________ Is s/he living with you? Yes/No/part time

Address (if different): ____________________

____

Occupation: ____________________ Age: ________

Email address(es): ____________________

Phone numbers: (H) ____________ (M) ____________ (W) ____________

What is your preferred contact number? (Please circle): *Home* *Mobile* *Work*

Can we leave a message at these numbers? (Please circle): *Yes/No* *Yes/No* *Yes/No*

Name: ____________________

Relationship to patient: ____________ Is s/he living with you? Yes/No/part time

Address (if different): ____________________

____

Occupation: ____________________ Age: ________

Email address(es): ____________________

Phone numbers: (H) ____________ (M) ____________ (W) ____________

What is your preferred contact number? (Please circle): *Home* *Mobile* *Work*

Can we leave a message at these numbers? (Please circle): *Yes/No* *Yes/No* *Yes/No*

Details of other family members

(e.g. siblings/parents/significant extended family – please continue on another sheet if necessary)

Tick if living with child

Full name: ______________________________ Age: ________

Relationship: ______________________ School / Occupation: ______________________ ☐

Full name: ______________________________ Age: ________

Relationship: ______________________ School / Occupation: ______________________ ☐

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Full name: ______________________________ Age: ________

Relationship: ______________________ School / Occupation: ______________________ ☐

Full name: ______________________________ Age: ________

Relationship: ______________________ School / Occupation: ______________________

Details of other agencies / practitioners

This is not consent to share information with these agencies or practitioners.

GP (if not referrer): ____________________

Address: ____________________

Phone: ____________________ Fax: ____________________

Please include here other practitioners, e.g. paediatricians / psychologists / therapists / social workers
Please continue on another sheet if necessary

Contact name: ____________________ Profession: ____________________

Agency name: ____________________

Address: ____________________

Phone/email: ____________________

Contact name: ____________________ Profession: ____________________

Agency name: ____________________

Address: ____________________

Phone/email: ____________________

Contact name: ____________________ Profession: ____________________

Agency name: ____________________

Address: ____________________

Phone/email: ____________________

School / Other Education / Occupation Details

This is not consent to share information with the school.

School/occupation: ____ Year: _____

Telephone: ___________________________ Contact persons:

Name: ____________________________________ Role: ___________________________

Name: ____________________________________ Role: ____________________________

Name: ____________________________________ Role: ____________________________

Any other information or details that might be helpful

I/we confirm that the details provided on this form are correct and can be used in relation to clinical work, including letters to referrer/general practitioner.

Signed: ____ Date: ___________________

Name: ________________________ Relationship to referred person: ___________________

Signed by young person: _____________________________________ Date: _____________
(if appropriate)