VPRS Victorian Paediatric Rehabilitation Service

VPRS Referral Form

SOURCE OF REFERRAL

Name of referrer		
Title/Position		
Relationship to client		
Phone number		Fax number
Email address		
Postal address		

CONSENT

Does the client/family/guardian consent to referral?	Yes / No
Does the client/family/guardian consent for VPRS to contact relevant professionals (as listed)	Yes / No

CLIENT DETAILS

Name			Male / Female
Date of birth			Age
Primary language			
Preferred language		Interpreter required: Yes / No	
Ethnicity/Cultural group		Indigenous status	
Medicare number			
Private health insurance	Insurer name	Policy number	
Compensable (TAC)	Claim number		
Client lives with			

PARENTS/GUARDIANS CONTACT DETAILS

Name		
Relationship to client		
Home phone		
Mobile phone		
Postal address		
Email address		

MEDICAL DIAGNOSIS & HISTORY

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REASON FOR REFERRAL

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Name ………………………………… **Designation** ……………………………**Signature** ………………………………. **Date** ………………

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CONTACT DETAILS

PAEDIATRICIAN DETAILS

Name		
Phone number		Fax number
Email address		
Postal address		

GP DETAILS

Name		
Phone number		Fax number
Email address		
Postal address		

SPECIALIST DETAILS

Name		
Phone number		Fax number
Email address		
Postal address		

PRESCHOOL/SCHOOL DETAILS

Name		
Grade/Year level		
Main contact person		
Phone number		Fax number
Email		
Postal address		

OTHER

Name		
Contact person		
Relationship to client		
Phone number		Fax number
Postal address		

OTHER

Name		
Contact person		
Relationship to client		
Phone number		Fax number
Postal address		

OTHER

Name		
Contact person		
Relationship to client		
Phone number		Fax number
Postal address		