Children's Allied Health Services - Referral Form

Phone: 1300 552 509 ■ Fax referrals to 03 7032 7524
Email: metroservicecoordination@lchs.com.au

Link Health and Community

Client Details:

Consent

Yes- ☐ Client consents for referral and information to be given to relevant persons.

Family Name:

Given Name:

Preferred Name/s:

Title: Date of Birth:

Birth sex: ☐ male ☐ female

URN *(existing clients only):*

Contact Details:

Address:

Suburb: Post Code:

Phone / Mobile:

Email:

Can we leave a message/send a SMS? ☐ Yes

Can we send information about our services? ☐ Yes

Country of Birth:

Preferred Language:

Interpreter Required: ☐ Yes ☐ No

Do you have a Healthcare card? ☐ Yes ☐ No

Card Number:

Indigenous Status:

☐ Aboriginal / Torres Strait Islander
☐ Both Aboriginal & Torres Strait Islander
☐ NOT Aboriginal or Torres Strait Islander

Who may we list as an additional contact?

(e.g Carer, parent, friend, emergency contact)

Name:

Contact Address:

Contact Phone Number:

Relationship to Client:

Who do we contact to make an appointment?

☐ Client ☐ Additional Contact:

☐ Other:

Referral Details:

Date of referral:

Referring Person:

Organisation:

Contact Details:

Services Requested *(select one or more services)*:

☐ Audiology
☐ Psychology
☐ Dietetics / Nutrition
☐ Occupational Therapy
☐ Physiotherapy
☐ Podiatry
☐ Speech Pathology
☐ Feeding Clinic
☐ Neurodevelopment clinic

Reason for referral:

Medical History:

Medications:

Updated July 2025

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