

# Schools, Health and Community Together Care Navigator Referral Form



## School child attends/will attend

☐ Daceyville Public School  
☐ Matraville Public School

☐ Eastlakes Public School  
☐ Matraville Soldiers' Settlement

## Parent/carer details

Name of parent/carer: \_\_\_\_\_ Medicare number: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Phone number: \_\_\_\_\_

Gender: ☐ M ☐ F ☐ Prefer not to say ☐ Prefer to self describe: \_\_\_\_\_

Address: \_\_\_\_\_ Country of birth: \_\_\_\_\_

Is an interpreter required? ☐ Yes ☐ No Language: \_\_\_\_\_

Does the child/family identify as Aboriginal or Torres Strait Islander: \_\_\_\_\_

## Child's details

Name of child: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Child's Medicare number: \_\_\_\_\_

Gender: ☐ M ☐ F ☐ Prefer not to say ☐ Prefer to self describe: \_\_\_\_\_

Who does the child live with? \_\_\_\_\_ Year at school: \_\_\_\_\_

Is the family/child already receiving services? ☐ Yes (if known please list) ☐ No

## Reason for referral

☐ Financial ☐ Developmental ☐ Parenting  
☐ Housing ☐ Behaviour ☐ Other (please list): \_\_\_\_\_

## Referral source

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Date of referral: \_\_\_\_\_ Does parent/carer consent to referral? ☐ Yes ☐ No

Does the parent/carer consent to their information being shared with the Care Navigator?

☐ Yes ☐ No

Does the parent/carer consent to receiving a client feedback survey? ☐ Yes ☐ No

Please note: By consenting to referral client will be contacted on the phone number provided.