**Enhancing Paediatrics in Primary Care (EPiPC) Clinical Query Proforma**

**FAX to (02) 69339268 or EMAIL to <MLHD-CCH@health.nsw.gov.au>**

**If no response received within 2 weeks, please contact <MLHD-CCH@health.nsw.gov.au> directly to ensure Clinical Query has been received.**

**Patient details\***

|  |  |  |  |
| --- | --- | --- | --- |
| Patient name |  | | |
| DOB |  | | |
| Medicare number |  | | |
| Primary carer name: |  | Primary carer DOB: |  |
| Address |  | | |
| Contact mobile |  | Email |  |

**Demographic details:**

Aboriginal and/or Torres Strait Islander  Refugee or Asylum Seeker

Culturally And Linguistically Diverse (CALD)  Interpreter required (language\_\_\_\_\_\_\_\_\_\_\_)

Out Of Home Care (OOHC)  DCJ/ support service involved

**Primary issue/concern\***

Early childhood developmental concern

Early childhood behavioural concern

Both early childhood developmental and behavioural concerns

**If developmental concern, please indicate which domain(s) is/are affected**

Speech & language  Fine motor  Gross motor  Personal/social

Problem solving/cognitive  Global

**Preferred format**

Email support

**Specific clinical question(s) for Community Paediatrician to address\***

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**Short summary of child’s medical history relevant to the clinical question(s) above\***

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**Services currently involved:**

Speech pathology  Occupational Therapy

Psychology/ counselling/ school counsellor  Physiotherapy

Dietitian  Other

**Further details of services involved**

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|  |

**Referrer details\***

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | | |
| Practice location |  | | |
| Preferred contact details for correspondence  (e.g. email/fax) |  | | |
| Signature |  | Date |  |
| If GP registrar, name and contact details of GP supervisor |  | GP supervisor co-sign |  |
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