Sleep and Settle Referral

Dear Dr Dylan Wilson,
Thank yor for seeing the below patient.
(Note: this referral will be allocated to the appropriate Leading Steps Paediatrician according to availability).

PATIENT DETAILS

PATIENT'S FULL NAME: ....

PARENT/GAURDIAN FULL NAME: ....

DOB: ...DD.../...MM.../...YYYY... ☐ FEMALE ☐ MALE

ADDRESS: ....

PHONE: ....

MEDICARE NUMBER: .... REF: .... EXPIRY: ....

☐ Private ☐ Third Party ☐ Self-funded

Health Fund: .... Membership No: ....

REASON FOR REFERRAL

- ☐ Baby not sleeping
- ☐ Baby irritable
- ☐ Feeding problems
- ☐ Parent request
- ☐ Other: ....

....

Is the baby known to a Leading Steps Paediatrician? ☐ Yes ☐ No

If yes, which Dr. ______________________________

MEDICAL HISTORY (or attach separately)

....

....

....

Current medications

....

....

Investigations to date

....

....

Please provide further information you feel may be of assistance

....

....

REFERRING DOCTOR

Name: ....

Address: ....

Phone: .... Signature: .... Date: ...DD.../...MM.../...YYYY...

Please FAX this form to 07 55 300 660 or email it to gcppaeds@healthscope.com.au and we will contact you to organise an appointment.

Phone 07 55 300 819 for further information and preparation advice.