



Queensland Government

Children's Health Services District
COMMUNITY CHILD HEALTH SERVICE
Primary Care Program
Central Intake Form

(Affix patient identification label here)

URN: Sex: M F
Family Name:
Given Names:
Address:
Date of Birth: Telephone:

CCHS ID Number:

Identify

Referrer Details:

Name / Designation: Phone:
Clinic / Service: Fax:
Signature: Date:

Situation

Is the client aware of and consented to the referral? Yes No
Privacy Consent Form Signed? (QH Health only) Yes No
Presenting Issues:

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Background

Family Details: Surname / Given Name	D.O.B	Relationship	Mobile Phone Contact

Services received from CCHS:

Other agencies / services involved:

Assessment

Current Assessment (including risk & protective factors)

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Request

IFSP Home Visit EIPS Other
Client Goal/s:
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Action taken: (Office use only)

DO NOT WRITE IN THIS BINDING MARGIN

CENTRAL INTAKE FORM – PRIMARY CARE PROGRAM – CCHS

V5 16/09/2009