OOHC Health Pathway Referral Form

OOHC HEALTH PATHWAY REFERRAL FORM

Participation on the Out-of-Home Care (OOHC) Health Pathway enables children and young people in statutory OOHC to receive timely assessment, planning, intervention, monitoring and review of their health needs.

This form should be completed by DCJ and emailed to the local OOHC Health Coordinator within 14 days of the child or young person's entry into care.

NSW Health only

Affix patient label here

ELIGIBILITY FOR THE OOHC HEALTH PATHWAY

Children and young people in NSW Statutory OOHC should be referred:

- if they entered care after 2010
- if they have significant health needs, regardless of their date of entry
- when they turn 15 years old, regardless of their date of entry. At this stage they will undertake a leaving care health assessment and planning. The OOHC Health Coordinator may request the caseworker to resubmit this referral form to assist with this process.

WHO SHOULD COMPLETE THIS FORM?

DCJ will usually complete the form though there may be occasions when it is completed by NGO service providers if the child has been in care for some time and was not initially referred to the Pathway by DCJ. However, please note that final approval of the referral form must be provided by DCJ delegate Manager Casework or above.

Referral Details *

Date form completed

Form completed by

Referring CSC

Contact person's name

Contact person's role

Phone

Email

Referral purpose

- ☐ Entry into statutory care
- ☐ Leaving care referral (young person is 15 years or over and has not previously been referred to the Pathway or the OOHC Health Coordinator has requested completion of the referral form as part of the leaving care planning process)

Child or Young Person's Identifying Details *

Name of child/young person

Preferred name

Also known as

ChildStory identifier

ChildStory case number

Date of birth

Age

Is the child or young person secured in ChildStory?

Gender identity

Gender pronouns

Aboriginal and/or Torres Strait Islander

Aboriginal Nation Group

Country of birth

Culturally and linguistically diverse background

Religion/Spirituality if applicable

Language spoken

Child Assessment Tool result

Child/young person address

Phone (if relevant)

Email (if relevant)

Agency case management assigned to, if not DCJ

Caseworker's name

Caseworker's phone number

Caseworker's email address

** mandatory fields*

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Legal Order and Parental Responsibility *

Legal order status

Does the Minister hold all aspects of parental responsibility for the child/young person? Yes No

If no, does the Minister hold parental responsibility for the aspect of health? Yes No

Does the Minister hold joint parental responsibility for the aspect of health with a birth parent or other person? Yes No

If interim order: Commencement date | Expiration date, if provided

If final order: Commencement date | Expiration date, if provided

Please note: the child/young person should not be placed on the OOHC Health Pathway if the Minister does not have parental responsibility for their health.

Placement Information *

Current placement

Placement type | Start date of current placement | Local health district of placement

Reasons why the child or young person entered OOHC (please provide as much information as you can about all the factors that contributed to the child/young people being assumed into care. This information assists NSW Health OOHC HPP in planning for assessments as well as preparing health plans and making referrals to appropriate services. Include relevant information from Safety and Risk Assessment).

NGO service provider name if relevant | NGO service provider phone number | NGO service provider address

Carer's name | Carer's phone number | Carer's address

Carer's email

Placement history

Has the child or young person previously been in OOHC? Yes No

When was the Minister first allocated parental responsibility for their health?

** mandatory fields*

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Please provide a brief placement history below:

Managing Agency	Placement type	Start date	End date	Exit reason

Family and Significant Relationships *

Family summary

Incudes birth parents and extended family members if their medical history is relevant to the medical care of the child

Relationship to child/young person	Name	Date of birth	Aboriginality (Yes/No)	CALD (Yes/ No)	Alive or deceased	Location (Suburb/State)	Interpreter required If yes, language and dialect	Known health or disability issues

What information can be disclosed about the child or young person by DCJ e.g. level of contact between birth family and child/young person, release of health information to birth family; release of carer information to birth family?

Siblings

Sibling's name	Date of birth	Aboriginality (Yes/No)	Legal status	Alive or deceased	Location (Suburb/State)	Case managed by NGO service provider	Known health or disability issues

** mandatory fields*

Education and Vocation

Is the child or young person enrolled in childcare, pre-school, primary or high school, TAFE, or an alternate learning program e.g. community development or employment program? Yes ☐ No ☐

If yes, name of facility

Year/Grade if relevant

Phone

Address

Has the child or young person been referred to the OOHC Education Pathway? Yes ☐ No ☐

Interests and Recreations

What activities does the child or young person enjoy?

Cultural Considerations

Describe the cultural needs of the child or young person in relation to accessing health services e.g. prefers Aboriginal medical practitioner, needs an interpreter, carer needs an interpreter (state language/dialect) etc.

Other Services and Supports

Are there any other services or supports in place for the child or young person? e.g. homework support, tutoring, mentoring, youth group, sporting club etc. Yes ☐ No ☐

Contact person and/or organisation	Address	Phone	Services/support

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Health Documentation

Please provide information regarding the following health documents:

If the child or young person does not yet have a Medicare Card, please provide the date of application for new card. Otherwise please provide the Medicare card number below:

Card number | Position number | Expiry date

Blue Book (if no and child < 6 yrs, CW to obtain) Yes No

Does the child/young person have a Health Care Card? Yes No

Immunisation History record. If yes, attach copy Yes No

If yes, please provide Health Care Card number Expiry date

If no, has the caseworker supported the carer to apply for the Health Care Card for the child or young person? Yes No

Name of Hospital and Place of Birth

Attach discharge summary (refer to relevant checklist on page 12)

Current Health

General health

Please describe the child or young person's general level of health:

Diagnosed medical conditions

Are there any diagnosed medical conditions? Yes No

If yes, please provide details:

Diagnosed medical condition	Name of practitioner	Date of diagnosis	Last review date

Medication

Does the child or young person take medication? Yes ☐ No ☐

If yes, please provide details:

Name of medication	Prescribed by	Dosage	Last reviewed	Psychotropic medication register

Treating practitioners

Treating practitioners who see the child or young person regularly are:

Practitioner	Name	Address	Phone
Current GP			
GP prior to placement			
Pediatrician			
Other practitioner			
Oher practitioner			

Medical appointments

Are there any scheduled health/medical/dental appointments? Yes ☐ No ☐ Unknown ☐

Provide appointment date/s and details:

Hospital admissions

Has the child or young person had any hospital admissions including operations? Yes ☐ No ☐ Unknown ☐

If yes, complete the table below:

Date of admission	Reason for admission	Name of hospital

Dietary restrictions and allergies

Are there dietary restrictions for health, lifestyle or religious reasons? Yes ☐ No ☐ Unknown ☐

If yes, provide details

Are there any allergies? Yes ☐ No ☐ Unknown ☐

If yes, are these allergies potentially life threatening eg anaphylaxis? Yes ☐ No ☐ Unknown ☐

List the allergies, including symptoms and treatment:

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Medical History

Maternal drug and alcohol history

Was there alcohol use by the mother during pregnancy? Yes ☐ No ☐ Unknown ☐

If yes, what was the source of this information?

- ☐ Child's mother
- ☐ Relative
- ☐ Eye witness e.g. caseworker, professional
- ☐ Maternal medical records
- ☐ Pregnancy/birth records
- ☐ Neonatal or paediatric records
- ☐ Child protection records
- ☐ Other - specify

Was there exposure to the drugs listed below during pregnancy?

- ☐ Nicotine (e.g. cigarettes/ inhalers/ e-cigs/chewed tobacco)
- ☐ Marijuana
- ☐ Heroin
- ☐ Amphetamines
- ☐ Cocaine
- ☐ Methadone
- ☐ Prescription drugs
  If yes, specify
- ☐ Other non-prescription drugs
  If yes, specify

If alcohol or drug use in pregnancy is reported above, please provide any information on:
The amount/frequency of alcohol or other drug use in pregnancy (if known):

How reliable is this estimate of the amount/frequency of alcohol or other drug use in pregnancy? (if known):

Physical health conditions

Please select any relevant conditions experienced by the child or young person below:

- ☐ Diabetes
- ☐ Vision concerns
- ☐ Fits, convulsions, epilepsy
- ☐ Allergies
- ☐ Urine infections
- ☐ Asthma or breathing issues
- ☐ Ear infections, frequent colds, throat infections
- ☐ Eating/feeding concerns
- ☐ Autoimmune disease e.g. type 1 diabetes
- ☐ Sexual health issues e.g. contraception and fertility management, sexually transmitted infection
- ☐ Physical disability such as paraplegia, quadriplegia, loss of limb or general mobility issue
- ☐ Meningitis
- ☐ Hearing concerns
- ☐ Infectious disease (e.g measles)
- ☐ Bedwetting
- ☐ Orthopedic problems
- ☐ Constipation
- ☐ Sleep issues
- ☐ Oral/dental health issues
- ☐ Skin problems
- ☐ Heart/Cardiac problems
- ☐ Other (please specify below)

Please provide details, including if the child or young person has received interventions for any of the above conditions:

Development Health

Please also select any areas of development that have been delayed, or if you have concerns about the child/young person's development in these areas:

- ☐ Cognitive development/learning difficulties
- ☐ Developmental delay/disability
- ☐ Motor development (fine and gross motor skills)
- ☐ Other (please list):
- ☐ Sensory (hearing, vision, touch skills)
- ☐ Speech, language and or communication skills
- ☐ Intellectual disability

Please provide details, including if the child or young person has received interventions in relation to their developmental health:

Psychosocial, Mental Health and Wellbeing

Please select any relevant conditions experienced by the child or young person from the options below:

- ☐ ADHD
- ☐ Psychosis
- ☐ Anxiety
- ☐ Attachment disorder
- ☐ Other (please list)
- ☐ Autism, if yes please indicate autism level if known
- ☐ Trauma including acute, chronic, complex and/or intergenerational
- ☐ Post-Traumatic Stress Disorder
- ☐ Depression

Please provide details, including if the child or young person has received interventions in relation to their psychosocial, mental health and wellbeing:

Disability History

Are there any diagnosed disabilities? If yes, please attach a copy (refer to relevant checklist on page 12)

Diagnosed disability	Name of practitioner	Date of diagnosis	Last review date

Has the child or young person been referred to the NDIS? Yes ☐ No ☐

If yes, does the child or young person have an NDIS Plan? Yes ☐ No ☐

If yes, attach copy (refer to relevant checklist on page 12)

If the child/young person has been referred but not met NDIS access requirements, please provide reasons why if known:

Has the child or young person been referred to the Early Childhood Approach (ECA)? Yes ☐ No ☐ N/A ☐

Has the child/young person been accepted to the ECA Pathway? Yes ☐ No ☐ N/A ☐

If yes, does the child or young person have an ECA Plan? Yes ☐ No ☐ N/A ☐

If yes, attach a copy (refer to relevant checklist on page 12)

If the child/young person has not been accepted are there reasons why?

Emotional and Behavioural Functioning

Describe the strengths of the child or young person's emotional and behavioural functioning:

Does the child or young person currently display any concerning behaviour or emotional issues e.g. difficulties with their identity and sense of connection, aggression, tantrums, detachment, disassociation, risky use of social media etc? Yes No Unknown

If yes, please provide further details regarding this behaviour or issues. Also include any current management strategies in place such as culturally appropriate behaviour support for the child/young person.

Does the child/young person engage in any risk taking or self-harming behaviour? Yes No Unknown

If yes, please provide further details regarding this behaviour or issues. Include any current management strategies in place.

Is the child/young person a risk to others or property (including risk of sexual harm to other children and young persons)? Yes No Unknown

If yes, please provide further details. Include any current management strategies in place.

Is substance use an issue for the child/young person? Yes No Unknown

If yes, please provide further details regarding the type/s of substance/s and frequency of use. Include any current management strategies in place.

Is there a current Behaviour Support Plan in place for the child/young person? Yes No Unknown

If yes, was the Behaviour Support Plan funded by the NDIS? Yes No Unknown

Date when the plan was approved Date when the plan was last reviewed

Please attach a copy (refer to relevant checklist on page 12)

Date when the plan was approved Date when the plan was last reviewed

Please attach a copy (refer to relevant checklist on page 12)

Daily Living Information

What level of independence and skills does the child or young person have in maintaining personal care?

Does the child or young person require assistance with personal care including dressing, eating and personal hygiene? Yes ☐ No ☐ Child is baby/infant ☐

Provide details regarding assistance required (response not required if child is a baby or young infant):

Describe the child or young person's ability to communicate, including whether any aids or assistance is required:

Does the child or young person need day to day assistance to meet health and disability needs e.g. assistance with taking medication? Yes ☐ No ☐ Child is baby/infant ☐

Please provide details of assistance required:

Does the child or young person require special equipment for daily living e.g. wheelchair, bed or bath hoist? Yes ☐ No ☐ Child is baby/infant ☐

Please provide details if equipment is required:

Describe how the child or young person relates to other people:

Does the child or young person have routines, habits and personal living arrangements that help them feel a sense of belonging or safety e.g. they sleep in a room with other children, they do not look adults in the eye, religious observance or cultural practice? Yes ☐ No ☐ Child is baby/infant ☐

If yes, provide further details:

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Reports and relevant documentation checklist

Reports and relevant documentation about the child/young person and their health should be attached to this referral if available. Please complete the table below to indicate what documentation is provided.

Name of document	Attached to referral	Date completed/approved
Birth Certificate (if available)	Yes ☐ No ☐	
Immunisation History	Yes ☐ No ☐	
NDIS Plan	Yes ☐ No ☐	
ECEI Plan	Yes ☐ No ☐	
OOHC Behaviour Support Plan	Yes ☐ No ☐	
NDIS-funded Behaviour Support Plan	Yes ☐ No ☐	
Pediatrician Assessment or Report	Yes ☐ No ☐	
Cognitive Assessment	Yes ☐ No ☐	
Speech Assessment	Yes ☐ No ☐	
Physiotherapy Assessment	Yes ☐ No ☐	
Occupational Therapy Assessment	Yes ☐ No ☐	
Mental Health Assessment	Yes ☐ No ☐	
Hospital Discharge Summaries	Yes ☐ No ☐	
Previous OOHC Health Management Plan (if child has been in care prior)	Yes ☐ No ☐	
2A Health Assessment (may be applicable to some districts)	Yes ☐ No ☐	
2B Assessment (may be applicable in some districts)	Yes ☐ No ☐	
Strengths and Difficulties Questionnaire completed by carer (may be applicable)	Yes ☐ No ☐	
Other – please provide details		

Referral approval considerations *

Please note that approval for the referral must be obtained from DCJ

Name of approving DCJ manager	Title	Date of approval	Signature

* mandatory fields

OOHC Health Pathway Referral Consent Form

FORM A: Consent for releasing and obtaining information regarding the child/young person for the purposes of health assessment and ongoing care and treatment *

To be completed by DCJ Manager Casework when a child or young person does not demonstrate sufficient maturity to make their own decision about participation on the OOHC Health Pathway (note maturity is generally considered able to be demonstrated from age 14 though in some instances may be younger as advised by a medical practitioner).

For the purpose of health assessment, and ongoing care and treatment any Local Health District will be authorised to have access to and release the health and medical records of _____ born _____ and to exchange information that is relevant to, the health, development and well-being of _____ with the persons/ organisations/practices listed below:

- Any NSW Local Health District (this would include NSW Government hospitals, clinics or medical practitioners, and the OOHC Health Pathway Coordinator)
- General Practitioner
- Pediatrician and/or medical specialist
- Aboriginal Medical Service
- Other health service(s)
- Other: NSW Department of Education

This consent is:

(a) to facilitate information exchange under the Health Records and Information Privacy Act 2002 (HRIPA), and is also supplementary to the ability to exchange information under Chapter 16A or s.248 of the Children and Young Persons (Care and Protection) Act 1998; and

(b) valid for the period that the child/young person remains in statutory OOHC, unless significant changes in circumstances occur or the child/young person is of sufficient level of maturity (this is generally considered to be from age 14 though in some instances maybe i.e. younger) and no longer wishes to participate on the OOHC Health Pathway Program.

Signature Manager Casework

Print name of Manager Casework

Date

Please click here to find out how to sign documents with a digital signature.

** mandatory fields*

OOHC Health Pathway Referral Consent Form

Form B: Consent for mature minor participation on the OOHC Health Pathway *

To be completed by the child/young person and caseworker if they demonstrate sufficient maturity to make their own decision regarding participation on the OOHC Health Pathway (note this is generally considered to be from age 14 though in some instances may be younger as advised by a medical practitioner). If the caseworker believes that the child/young person has an intellectual disability or cognitive impairment that would prevent them from providing consent then this should be confirmed by a medical practitioner.

What is the OOHC Health Pathway?

The OOHC Health Pathway is a program run jointly by the Department of Communities and Justice and NSW Health to meet the health needs of children and young people in OOHC. Under the Pathway, your health needs are assessed and referrals to health services are provided to meet those needs. Your health is reviewed regularly to ensure your needs are being met. It is important that you are able to be involved in this process and your consent is required to protect your privacy. If at any point you want to withdraw your consent, you can do this by talking to your caseworker or OOHC Health Coordinator.

Who can access your health records?

To provide you with the best health care, your health records may be accessed by, and released to any of the following persons/ organisations/practices:

- Any NSW Local Health District (this would include NSW Government hospitals, clinics or medical practitioners, and your OOHC Health Pathway Coordinator)
- NSW Department of Education
- Your General Practitioner
- Your Pediatrician and/or medical specialist
- Aboriginal Medical Service
- Other health service(s)

Any of the above persons/organisations/practices are expressly authorised to provide access to records and/or information to the Local Health District and to receive records and/or information from the Local Health District.

The section below should be completed by the child/young person:

I understand:

- ☐ All children and young people entering statutory OOHC are referred to NSW Health for health assessment, planning, health services and review.
- ☐ My consent is required for the exchange of my information between DCJ, NSW Health, my carer if relevant and any of the services or people listed above.
- ☐ My consent is voluntary and I do not have to give consent.
- ☐ My consent means that my health and medical records will be exchanged between DCJ and Health to enable my participation in the Health Pathway.
- ☐ I can obtain copies of my health documentation, including information about the Health Pathway, or receive support to obtain information if it is not available to DCJ by speaking with my caseworker.
- ☐ I can withdraw my consent to participate in the Health Pathway at any time by speaking with my caseworker.

I, _____ consent to:

- ☐ My health and medical information being exchanged for the purposes of my participation on the OOHC Pathway as detailed above; and
- ☐ Participation on the OOHC Pathway; this includes attending appointments and being involved in planning and decisions about my health.

Signature child/young person	Print name of child/young person	Date

The section below should be completed by the caseworker:

I, _____ have:

- ☐ Explained the OOHC Health Pathway to _____
- ☐ Formed the view that the child/young person has sufficient understanding to make a decision about their participation.

Signature of caseworker	Print name of caseworker	Date

* mandatory fields

OOHC Health Pathway Referral Checklist

Child/young person

Consent is required from the child/young person if they have sufficient maturity to make their own decisions (generally this is considered to be from 14 years, though in some instances may be younger). A child under 14 years can be assessed as competent by a medical professional. A child/young person providing consent must sign Form B: Consent for mature minor participation on the OOHC Health Pathway at the end of this referral.

	Please select	Comments/Concerns
Has the child/young person signed Form B: Consent for mature minor participation on the OOHC Health Pathway?		

Authorised carers

	Please select	Comments/Concerns
Has the purpose of the OOHC Health Pathway been explained to the authorised carer?		
Does the carer understand their role in implementing the Pathway e.g. taking the child/young person to appointments, implementing Health Management Plan recommendations?		
Has the carer been informed of this referral to Health?		
Has the carer provided their verbal consent for the release of their contact details?		

Birth parent/s

	Please select	Comments/Concerns
Has the verbal consent of the birth parent/s been provided for the release of their personal contact details and health information relating to themselves and/or their child/ren not in care for whom they have a parental responsibility.		

Please make a file note to record that verbal consent has been obtained from the birth parent/s. If verbal consent is not obtained, then do not include any information regarding birth parents' health.

Extended family members

	Please select	Comments/Concerns
Have extended family members with medical history relevant to the medical care of the child given verbal consent for the release of information regarding their health.		

Please make a file note if verbal consent has been obtained. If verbal consent is not obtained, then do not include any information regarding extended family members' health.