Health
Northern Sydney
Local Health District

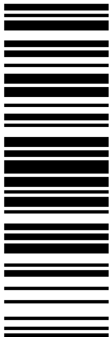
This PDF will expire on 1 October 2022

FAMILY NAME		MRN	
GIVEN NAME		☐ MALE	☐ FEMALE
D.O.B. DD / MM / YYYY		M.O.	
ADDRESS			
		PH	
M/C		FIN	
LOCATION / WARD		ADM DD / MM / YYYY	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Facility: COM HKH MQE MVH RNS RYD

REFERRAL - VACCINATION SEDATION AND PROCEDURAL SUPPORT



COR5220

Referral Details

Referral initiated by: ☐ GP ☐ Medical Officer ☐ Other....................

Name.................... Contact number....................

Practice address....................

Date of referral: __ / __ / ____ Date received: __ / __ / ____ Received by....................

Reason for referral:

....

Patient Details

Name.................... DOB: __ / __ / ____ MRN ....

Address....................

Contact number ....

Are you of Aboriginal or Torres Strait Islander Origin? ☐ Yes – Aboriginal ☐ Yes – Torres Strait Islander ☐ Yes – both ☐ Neither ☐ Unknown

Language: ☐ English ☐ Other (specify).................... ☐ Interpreter required ☐ Interpreter booked

Medicare number .... Exp.................... Reference number....................

Concession card number .... Exp....................

Person to Contact/Person Responsible

Name.................... Contact number....................

Email....................

Medical History

Weight.................... kg **Height** .... cm

☐ Intellectual disability (details)....................

☐ Challenging behaviour (details)....................

☐ Other diagnosis (details)....................

Previous vaccination attempts: ☐ Yes ☐ No

Details....................

Allergies:

....

Medications:

....

....

BINDING MARGIN – NO WRITING
Holes punched as per AS2828.1:2019

CATALOGUE NUMBER NS12570-E OCT21/V1

Health
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Facility: COM HKH MQE MVH RNS RYD

REFERRAL - VACCINATION SEDATION AND PROCEDURAL SUPPORT

FAMILY NAME		MRN	
GIVEN NAME		☐ MALE	☐ FEMALE
D.O.B. DD / MM / YYYY	M.O.		
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		PH	
M/C	FIN		
LOCATION / WARD		ADM DD / MM / YYYY	

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Health professionals involved:

Previous experience with nitrous: ☐ Yes ☐ No

Details

Previous experience with midazolam: ☐ Yes ☐ No

Details

Previous experience with sedation methods: ☐ Yes ☐ No

Details

Upcoming procedures/surgeries: ☐ Yes ☐ No

Details

Telephone Planning Discussion

Background information (disability, interests, likes/dislikes, rewards that work well, medical needs)

Behavioural support plan ☐ Yes ☐ No

Details

Ability to follow instructions

Comforters to attend appointment with

Parents/carers attending

Discussed easy clothing to wear (easy to roll up sleeves) ☐ Yes ☐ No

Environmental factors to assist patient (low stimulus, virtual reality)

Timing (best time of day, time needed to settle in, better to get in and out quickly)

Information to be emailed to person responsible:

☐ Confirmation of appointment ☐ Instructions e.g. location ☐ Map
☐ Fact sheet about vaccine ☐ Social story PDF ☐ Link for video about vaccination

Vaccination 1 date: __ / __ / ____ **time**: __ : __ **Vaccination 2 date**: __ / __ / ____ **time**: __ : __

Location **Location**

Additional notes:

Name Signature

Designation Date: __/__/____

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MARGIN – NO WRITING