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 ***Ratoka Whakawhanake Tamaiti***

 ***Child Development Service***

 ***Vera Hayward Centre***

***V***

Dunedin Hospital

**Referral Form for Children under 5 years**

Thank you for taking the time to contact our service. Please provide as much information as you can, as this will help us decide whether we are the best service to support your tamaiti.

Name of child

Address

DOB       NHI

Ethnicity       Language/s spoken at home

Parents/caregivers

Contact phone number/s:

GP

Preschool/Kohanga/Kindergarten

Contact person there

Parent/caregiver permission to contact preschool: Yes [ ]  No [ ]

Who is filling in this form

Relationship to child       Phone

Parent/caregiver permission for this referral: Yes [ ]  No [ ]

Please describe the concerns you have about your child’s development

What does your child enjoy doing?

Please describe any concerns you have about your child’s:

* Hearing/vision
* Health
* Speech and Language skills
* Learning/thinking Skills
* Physical skills
* Behaviour
* Sensory
* Getting on with other children
* Feeding
* Self-care

Does your child and/or whānau have other services involved (e.g., Family Start, Public Health Nurse, Ministry of Education) – now or in the past

Please attach information from preschool/kohanga if you have any

Please e-mail completed form to: ChildDevelopmentServiceDn@southerndhb.govt.nz

or post to the address above