

## Specialist Team for Intellectual Disability Sydney – STriDeS Referral

People with intellectual disability and complex health conditions that cannot be met by usual healthcare may be referred to STriDeS. Please:

- Ask your GP or specialist to complete the first section for Medicare billing purposes
- Include a health summary.
- Please attach any relevant medical reports or additional information from other service providers.
- If you require assistance completing this form, please contact STriDeS on 9378 1364 or email [SLHD-STRIDES@health.nsw.gov.au](mailto:SLHD-STRIDES@health.nsw.gov.au).

### Section 1 – Medical Officer to complete

Date referral completed:

#### Details of Medical Officer completing this section of the referral

Full name:

Provider number:

Practice address:

Phone number:

Fax number:

Email:

Signature:

GP's name and practice, if different from above:

Tick which STriDeS specialist you are referring the client to:

- Dr Jaqueline Small (Paediatrician)     Dr Alexis Berry (Adult physician)

*STriDeS will organise a case conference with the referring doctor / GP following the clinic assessment.*

#### Client's details

First name:

Last name:

Date of Birth:

Phone:

Client's preferred gender:     Male     Female     Prefer not to say     Other

Address:

Postcode:

Type of residence:

Medicare number (including client's reference number):

Does the client require an interpreter?     Yes     No

If yes, what language?

Does the client have an intellectual disability that has been confirmed, or is suspected?

- Yes  Suspected

If yes, please attach reports of cognitive assessment. If suspected, please provide details:

**Please provide the reason/s for this referral**

1. Unresolved health care issue (physical health):
  
2. Unresolved healthcare issue (mental health):
  
3. Current hospitalisation:
  
4. Risk of hospitalisation:
  
5. Other - Please provide further details regarding the reason for referral:

Please provide any details of treatments relating to the above reasons:

**Section 2 – to be completed by referring doctor or person responsible**

**Parent / Guardian / Person Responsible**

Full name:

Phone contact:

Relationship:

Who has provided **consent** for this referral, if different from above? Please provide name, relationship and contact number:

**Main contact details for appointments**

Client                      Carer                      Support worker                      Other

Full Name:

Phone:

Email:

*Please return this referral form to STRiDeS via:*

**Email:** [SLHD-STRIDES@health.nsw.gov.au](mailto:SLHD-STRIDES@health.nsw.gov.au)

**Mail:** STRiDeS  
Croydon Health Centre  
24 Liverpool Road  
Croydon, NSW, 2132

**Fax:** 9378 1332

Thank you.