

Sleep and Settling Program Referral Form



Referral Information			
Referred By:		Date:	
Job Title:		Phone:	
Organisation:		Email:	

Client Signature:		Date:	
Verbal Consent Obtained:	YES / NO	Date:	
URGENT REFERRAL:	YES / NO		

Client Name:	
CDIS No:	
ATSI / CALD Status:	
Primary Caregivers Name:	
Primary Caregivers Phone:	
Best Contact Time:	
Email:	

Sleep Assessment

Is your child's sleep a concern?	
Is your child's sleep a concern for other family members?	
How long has your child's sleep concerned you or a family member?	
Would you or a family member like further information and support around your child's sleep?	

Child's sleeping arrangements (tick those applicable)			
Cot in parents' room	<input type="checkbox"/>	Bed sharing in parents' room	<input type="checkbox"/>
Cot in separate room	<input type="checkbox"/>	Bed sharing in child's room	<input type="checkbox"/>
Cot in room with sibling	<input type="checkbox"/>	Co-sleeping – sharing a sleep surface with a child, and may include sofa or floor	<input type="checkbox"/>
Other	<input type="checkbox"/>	Please specify: Tim (fa) camping out in spare bed in Mason's room.	

OFFICE USE ONLY	DATE:	
CLIENT NAME:	MCH NURSE	
NEAREST MCH CENTRE:	SIGNATURE:	

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Child's sleeping associations (tick those applicable)		
Wrapping		Feeding
Sleeping Bag		Cuddling or held
Dummy / soothers / pacifier		Car
Comfort toy		Music / White Noise
Patting / stroking		
Other		Please specify:

Feeding (age appropriate)	
DIET	
Breast feeding	
Formula feeding	
First foods	
Meals (breakfast, lunch, dinner)	
Snacks (morning tea, afternoon tea, supper)	

Sleep patterns – day (7am – 7pm)	
Average number of sleeps	
Average length of each sleep	
Average number of hours in total	
Does child need support to resettle during sleep/s?	
Average number of wakeups	

Sleep patterns – night (7pm – 7am)	
Average number of sleeps	
Average length of each sleep	
Average number of hours in total	
Does child need support to resettle during sleep/s?	
Average number of wakeups	

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Other Information
<p>Has been referred to any other services to assist with sleep and settling?</p>

Maternal and Child Health Nurse:		Date:	
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Privacy Statement

The personal and/or health requested on this form is being collected by Moira Shire Council for the purpose of providing Maternal and Child Health Services. The information will be used solely for the purpose it was collected and/or directly related purpose. Council may disclose this information to other organisations if required by law. If you do not provide this information, Council may not be able to provide services to your family/child within the Sleep and Settling Program. You can find out more about how we use and protect your information by viewing our Privacy Statement on our website - www.moiravic.gov.au. If you require access to the information you have provided, please contact Council.

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