Flying Start Paediatric Service information sheet and referral form

Flying Start is a **free** multi-disciplinary clinic, delivering holistic paediatric assessments in community for children that need specialist support. Our paediatrician will work with families, local GPs, allied health clinicians and community (nurses, school, other supports) to check your child's physical, mental and behavioural development and to support with care planning, treatment and medical management.

Who is eligible?

- Children aged 0-18 with developmental concerns, such as autism, ADHD, learning difficulties or conditions needing diagnoses.
- Children who don't have a paediatrician.
- Children who are listed on a Medicare card, and who currently see a GP.

How do I refer?

Complete the referral below and email to **flyingstart@marathonhealth.com.au**
If you need help with your referral, contact us at **flyingstart@marathonhealth.com.au** or get in touch with your school support learning team, GP or Wellbeing and Health In-reach Nurse (WHIN).



Form completed by		Date completed	

Child details					
Legal first name:			Legal surname:		
Preferred name:		Date of Birth:		Pronouns:	
Address:				Suburb:	
Postcode:	Phone:		Best email contact:		
Medicare number:			Position on card:	Expiry:	

Cultural and Identity Information
We ask these questions so we can provide respectful, culturally safe and inclusive support. You can choose not to answer any question, and this will not affect your access to the program.

Gender How is the child's gender described?	☐ Female	☐ Male	☐ Non-binary	☐ We/they prefer a different term (please specify):	☐ Prefer not to answer
Is the child of Aboriginal or Torres Strait Islander origin?	☐ No	☐ Yes, Aboriginal	☐ Yes, Torres Strait Islander	☐ Yes, both Aboriginal and Torres Strait Islander	☐ Prefer not to answer
Country of birth: ☐ Prefer not to answer			Main language spoken at home: ☐ Prefer not to answer		

Guardian/Carer details				
☐ Parent	☐ Guardian	☐ Carer	☐ Public guardian	☐ Other
Name:		Preferred contact:	☐ Phone ☐ Email ☐ Both	
Phone:		Email:		
Other contacts (*Preschool/day care/school)*:				

GP details			
GP name:			
GP email:		GP phone:	
GP Practice:	☐ AMS ☐ OCHRE ☐ Other *(please specify)*		

Do you need communication assistance? Eg Interpreter, communication device	
☐ Yes *(please describe)*	☐ No

Referred by (Name)		**Referral date**	
Organisation		**Phone**	
Email			

Reason for referral to the Variety Flying Start clinic:
List developmental concerns or delays

Relevant case history:

Please ask the family these questions

What factors have impacted your access to a paediatrician?	☐ Geographic/transport barriers ☐ Workforce Shortages ☐ Waitlists ☐Other (specify)_____ ☐ No Barrier	
Is the child on the NDIS or Early Childhood Approach?	☐ Yes ☐ No	*If No, complete an application for Variety's We Care grant for allied Health pre-assessment.*
Has the child seen an Occupational Therapist (OT) in the last 12 months	☐ Yes ☐ No	*If Yes, please provide a copy of the assessment. Your child may not need another assessment completed.*
Has the child seen a Speech Pathologist in the last 12 months	☐ Yes ☐ No	*If Yes, please provide a copy of the assessment. Your child may not need another assessment completed.*
Has the child seen a Paediatrician in the last 12 months?	☐ Yes ☐ No	*If Yes, please provide a copy of the assessment. Your child may not need another assessment completed.*

Marathon Health – Flying Start Paediatric Service Client Consent Form

Your Privacy and Personal Information

Marathon Health takes your privacy seriously.

Marathon Health follows the **Privacy Act 1988** and related privacy laws. This means:

- Any personal or health information about you is kept confidential
- Information shared with Marathon Health is only used to support your care
- Your information is only shared with health professionals involved in your care
- Sometimes we must share information because the law requires us to, such as for a court order (subpoena) or a child protection request (Chapter 16A)

Client Consent - Your Agreement

By signing below, I understand and agree that:

- My/my childs personal and health information may be collected, used, and shared with relevant health providers involved in my care
- Information may be used to help improve Marathon Health programs that does not identify my child or myself. This information may be shared with funding bodies or used internally.
- Information is kept securely and I can ask to see it at any time
- Information may be shared if required by law (for example, a court order or child protection law)
- Marathon Health can confirm Medicare concessions are available for bulk billing

I also agree that my health information may be shared with the people at my child's school and the GP.

Child's Name:	Child's DOB:
Parent/Guardian Name:	
Parent/Guardian Signature:	Date: