

REFERRAL FORM

ELIGIBILITY CRITERIA:

- Young people aged 8 – 25 (inclusive)
- Experiencing moderate symptoms of mental health concerns
- At high risk of developing severe and complex mental illness
- Functional impairment
- Consent to referral and voluntary participation
- Expected benefit from engagement with service

REFERRAL PROCESS

- **Referral from Service Providers will require a copy of ALL relevant collateral information (including any assessments, discharge summaries & recovery documents) prior to a referral being triaged.**
- All Clients referred will be triaged by Clinical Team during Case Review to assess eligibility and suitability.
- Outcomes will be provided directly to service provide via email or telephone

1. REFERRER (INDIVIDUAL COMPLETING THIS DOCUMENT)

Contact Name: [Click here to enter text.](#)

Position / Relationship: [Click here to enter text.](#)

Organisation (if applicable): [Click here to enter text.](#)

Postal Address: [Click here to enter text.](#)

Post Code: [Click here to enter text.](#)

Phone: [Click here to enter text.](#)

Mobile: [Click here to enter text.](#)

Fax: [Click here to enter text.](#)

Email: [Click here to enter text.](#)

Signed: _____

2. YOUNG PERSON BEING REFERRED (THESE DETAILS WILL BE USED TO CONTACT THE YOUNG PERSON /PARENT, GUARDIAN)

First Name: [Click here to enter text.](#)

Surname: [Click here to enter text.](#)

Date of Birth: [Click here to enter text.](#)

Age: [Click here to enter text.](#)

Gender: M F Other

Address: [Click here to enter text.](#)

Suburb: [Click here to enter text.](#)

Postcode: [Click here to enter text.](#)

State: [Click here to enter text.](#)

Home Ph: [Click here to enter text.](#)

Mobile: [Click here to enter text.](#)

If consent provided by young person please provide details of their parent/ guardian: [Click here to enter text.](#)

NOTE TO REFERRER

Please provide as much information as possible as it ensures the best quality of care, outcome and if required referral is afforded to the young person being referred.

3. INFORMATION ABOUT THE YOUNG PERSON

(If Applicable) Risk to self or others (Include self-harm/ suicide attempts, violence, threats of violence)

Date	Type of Behavior	Reason for Behavior	Outcome/ Treatment Provided
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.

Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.

(If Applicable) Other Agencies / health care providers currently involved within the individuals care: (e.g.: Government, non-Government, GP's, Psychiatrists, and Community Services)

Name of Organisation	Contact Person	Address	Phone
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.

4. PRESENTING ISSUES

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> ANXIETY | <input type="checkbox"/> PAIN MANAGEMENT ISSUES | <input type="checkbox"/> ADHD / ADD | <input type="checkbox"/> REFUSING SCHOOL |
| <input type="checkbox"/> FAMILY PROBLEMS | <input type="checkbox"/> FINANCIAL DIFFICULTY | <input type="checkbox"/> DIFFICULTY SLEEPING | <input type="checkbox"/> DEPRESSION |
| <input type="checkbox"/> PHYSICAL ABUSE | <input type="checkbox"/> LOSS OF APPETITE | <input type="checkbox"/> EATING PROBLEMS | <input type="checkbox"/> SELF HARM |
| <input type="checkbox"/> RELATIONSHIP ISSUES | <input type="checkbox"/> PHYSICAL DISABILITY | <input type="checkbox"/> DRUG ABUSE | <input type="checkbox"/> HISTORY OF HOSPITALISATION |
| <input type="checkbox"/> HARM OR THREATS TO OTHERS | <input type="checkbox"/> SEXUAL ABUSE | <input type="checkbox"/> INTELLECTUALLY IMPAIRED | <input type="checkbox"/> STRESS |
| <input type="checkbox"/> DOMESTIC VIOLENCE | <input type="checkbox"/> PTSD / TRAUMA HISTORY | <input type="checkbox"/> BODY IMAGE | <input type="checkbox"/> SUICIDAL |
| <input type="checkbox"/> EMOTIONAL ABUSE | <input type="checkbox"/> SOCIAL PROBLEMS AT SCHOOL | <input type="checkbox"/> BULLYING OTHERS | <input type="checkbox"/> PENDING LEGAL MATTERS |
| <input type="checkbox"/> PRESENTATION TO ED OR HOSPITAL | <input type="checkbox"/> HALLUCINATIONS AND DELUSIONS | <input type="checkbox"/> CRYING | <input type="checkbox"/> ASPERGERS / AUTISM |
| <input type="checkbox"/> PAST OR PRESENT CONTACT WITH CHILD SAFETY | | <input type="checkbox"/> OTHER Click here to enter text. | |

In the field below, please include the following information:

- Relevant assessment information such as *current diagnosis, concerning behavior, truancy, high acuity, involvement with Child Safety, Police or Youth Justice, etc.*
- Relevant background: (consumer and family psychiatric/medical history, current family situation, level of functioning)
- Summary of current care: (therapeutic interventions, current medications, referrals, other service providers)
- Please indicate what the young person hopes to achieve from referral?

[Click here to enter text.](#)

5. CONSENT OF YOUNG PERSON BEING REFERRED

I am aware that this referral is being made. I understand that I can withdraw from this referral or from the referred service at any time.

Please NOTE: Referrals will not be processed without signed consent.

I give permission for Redlands Youth Service to use my contact details above for future contact with Yes No me.

I give permission for the staff of Redlands Youth Service to obtain relevant information from Yes No government and non-government agencies, from doctors and other health professionals specifically relevant to my care whilst being a client of Redlands Youth Service.

I give permission for **Redlands Youth Service** to contact the referrer and advise once an appointment Yes No has been arranged.

Signed: _____ **Print Name:** [Click here to enter text.](#) **Date:** [Click here to enter text.](#)
If under 18 years of age authorization ideally should be provided by a parent/ guardian.

Parent/ Guardian Signed: _____ **Print Name:** [Click here to enter text.](#) **Relationship:** [Click here to enter text.](#)

6. THANK YOU FOR YOUR REFERRAL

Please return this form to Redlands Youth Service

Unit 3a/77 Shore St West, Cleveland
Email redlandsyouth@aftercare.com.au
[\(07\) 3446 6500](tel:(07)34466500)

7. WHAT NEXT?

- On receipt of a referral form the referral will be presented at Case Review
- **Redlands Youth Service** will contact the service provider to advise of outcome and then if applicable contact the young person to arrange an appointment.
- All initial appointments will be with a **Redlands Youth Service** Clinician, this process takes between 1 – 2 hours.