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

☐ Anxiety	☐ Pain Management Issues	☐ ADHD / ADD	☐ Refusing School
☐ Family Problems	☐ Financial Difficulty	☐ Difficulty sleeping	☐ Depression
☐ Physical Abuse	☐ Loss of Appetite	☐ Eating Problems	☐ Self Harm
☐ Relationship Issues	☐ Physical disability	☐ Drug Abuse	☐ History of hospitalisation
☐ Harm or threats to others	☐ Sexual Abuse	☐ Intellectually Impaired	☐ Stress
☐ Domestic Violence	☐ PTSD / Trauma History	☐ Body Image	☐ Suicidal
☐ Emotional Abuse	☐ Social Problems at School	☐ Bullying Others	☐ Pending Legal Matters
☐ Presentation to ED or Hospital	☐ Hallucinations and delusions	☐ Crying	☐ Aspergers / Autism
☐ Past or present contact with Child Safety		☐ 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 me. ☐ Yes ☐ No

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

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

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

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.