Wheatbelt Outreach

Referral Form

Please email this referral to duty.officer@youthfocus.com.au

**Referring Service Provider Details**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |   | Service Provider: |   |
| Telephone: |   | Mobile: |   |
| Email: |   | GP Details: |   |

**Young Persons Details**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | DOB:  | \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ |
| Address:  |
|  |
| Postcode: |   | Telephone: |   |
| Mobile: |   | Gender:  |   |
| Aboriginal and/or Torres Strait Islander: |   | Current Age:  |   |
| Next of Kin Name:  |   | Telephone:  |   |
| Has the referral beendiscussed with the Young Person? Yes / NoAre they willing to engage with Youth Focus? Yes / No | Referral has been discussedand consent form has beensigned by Parents/Carers of Yes/No.Young Person? |
| Current Medications (if any): |   |
| Location of Young Person:  |   |
| Location Young Person would like to be seen: |   |

**Reason for Referral**

Please provided as much information as possible – Why does the young person want counselling? What triggered the referral?

Presenting Issues (tick as many relevant boxes)

|  |  |
| --- | --- |
| Severe Anxiety |[ ]  Severe Depression |[ ]
| Social/Peer Issue |[ ]  School Engagement Issues |[ ]
| Grief and Loss |[ ]  Trauma |[ ]
| Alcohol and/or Drug Issues |[ ]  Self Esteem |[ ]
| Family Conflict |[ ]  Body Image/Eating Disorder |[ ]
| Schizophrenia |[ ]  Schizo-affective disorder |[ ]
| Early on-set Psychosis |[ ]  Bipolar Disorder |[ ]
| Conduct Disorders |[ ]  Suicidal Intent |[ ]
| Other (Please specify) |[ ]   |
|   |

**Risk**

Are you aware of any risks for the young person? Yes / No

If yes please specify;

Is Parent/Carer aware? Most Recent Incident? How long has this been an issue for the young person? Has the young person needed medical treatment (hospital, GO, Nurse?)

**Previous/Current Support**

Has the young person had counselling before?

Yes / No

Are they engaged in any other support for their presenting

Issues (i.e GP, Youth Worker, CAHMS, Support Worker,

School Support Staff – school Psychologist, School Chaplain)

Yes / No

If yes, please specify & provide contact names & phone numbers.

Please provide any other relevant information.

I verify that the information disclosed in this referral is accurate to the best of my knowledge. Please sign below;

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_