Wheatbelt Outreach

Referral Form

Please email this referral to [duty.officer@youthfocus.com.au](mailto: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 been  discussed with the  Young Person? Yes / No  Are they willing to  engage with Youth Focus? Yes / No | | | | | | | | | Referral has been discussed  and consent form has been  signed 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: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_