|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Young Person’s Details: | | | | | | | | | | | | | | |
| Full Name: | | | | | | | | | | | | | | |
| Date of Birth: | | | Gender: | | | | | | | | | | | |
| Phone Number (home and/or mobile): | | | | | | | | | | | | | | |
| Address: | | | | | | | | | | | | | | |
| Email: | | | | | | | | | | | | | | |
|  | | | | | |
| Can we use SMS to confirm appointments? | Yes |  | | No |  |
|  | | | | | |
| If the young person is under 16, is their parent/caregiver aware of the referral? | | | | | | | | Yes | |  | | No | |  | |
|  | | | | | | | | | | | | | | |
| Family Member/Emergency Contact: | | | | | | | | | | | | | | |
| Full Name: | | | Phone Number: | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| Referrer Information: | | | | | | | | | | | | | | |
| Name: | | | | | | | | | | | | | | |
| Phone: | | | | | | | | | | | | | | |
| Email: | | | | | | | | | | | | | | |
| Relationship to young person: | | | | | | | | | | | | | | |
| Position and organisation: | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| Does the young person currently receive support from any other services?  If so, please specify who, from which service(s), and their contact details. | | | | | | | Yes | |  | | No | |  | |
|  | | | | | | | | | | | | | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Appointments: | | | | | | | |
| Who should be contacted to book appointments? | | | | | | | |
|  | | | | |
| Young person |  | Referrer |  | Family Member | |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| What is the reason for Referral? | | | | | | | | | | | | | | |
|  | | | |
| Anxiety |  | Conflict in Relationships | |  | | Stress Related | | | |  | | Social Isolation |  |
|  |  |  |  |  | |  | | | |  | |  |  |
| Depression |  | Alcohol/Substance Use | |  | | Medical Issues | | | |  | | Other |  |
|  | | | |
| Does the young person have a Mental Health Treatment Plan? | | | | | Yes | |  | No |  | |
|  | | | | |  | |  |  |  | |
| Have any relevant assessments been completed?  If so, please attach. | | | | | Yes | |  | No |  | |
|  | | | |
| Please provide a brief explanation of the reason for referral – what are the presenting issues, and what type of support are you requesting, for this young person?  **Are you concerned with this person’s risk towards themselves or others? YES NO**  **If you have answered ‘yes’ - please identify how, and provide as much detail as you can.**  Please note: Moderate to High Risk young people may not be appropriate for this service.  Mental health services can be contacted on: **CAMHS** 8724 7055 (under 16yo) or  **Country SA Mental Health Services** 8721 1507 (over 16yo) or  **Adult Mental Health Services 24hr Crisis Assistance** 13 14 65 | | | | | | | | | | | | | | |