|  |  |
| --- | --- |
| Date of referral |  |
| Title | 🞎 Miss 🞎 Master 🞎 Ms 🞎 Mrs 🞎 Mr 🞎 Other  |
| First Name  |  | Last Name  |  |
| Preferred Name |  | Date of Birth  |  |
| Birth Sex | Gender assigned at Birth? | Optional | Preferred pronouns? |
|  🞎 Male 🞎Female  | 🞎 She 🞎 He 🞎 They 🞎 Other  |
| Gender Identity | 🞎 Female 🞎Male 🞎 Non-Binary 🞎 Different Identity *(Please specify)* |
| Country of Birth  |  | Indigenous Status |
| Nationality |  | 🞎 Aboriginal 🞎 Australian/Non-Indigenous 🞎 Aboriginal/Torres Strait Islander 🞎 Torres Strait Islander 🞎 Prefer not to say |
| Preferred Language  |  |
| Do you require an interpreter? |  🞎 Yes 🞎 No |
| *If Yes, please specify?* |  |
| *Address* |  |
| *Contact No.*  |  | Email Address |  |
| *Medicare No.*  |  | Position  |  | Expiry date  |  |
| **Parent/Caregiver 1**  |
| First Name  |  | Last Name  |  |
| Address |  |
| Relationship to young person  |  |
| Phone Number  |  | Email Address |  |
| **Parent/Caregiver 2** |
| First Name  |  | Last Name |  |
| Address |  |
| Relationship to Young person  |  |
| Phone number  |  | Email Address |  |
| **Family information** |
| Parents relationship Status  |  |
| Court orders in place | 🞎 Yes 🞎 No | Child Protection Involvement  | 🞎 Yes 🞎 No |
| **Siblings**  |
|  |
|  |
| **School details**  |
| School Name  |  | Grade |  |
| Address |  |
| Is the young person experiencing bullying? | 🞎 Yes 🞎 No | Severity  | 🞎 Mild 🞎 Moderate 🞎 Severe |
| **Suicide Ideation/ Self-Harm** |
| Is there current or previous Suicide Ideation? | 🞎 Yes 🞎 No 🞎 Not Sure  |
| Is there current or previous self-harm? | 🞎 Yes 🞎 No 🞎 Not Sure  |
| **Comments:** |
| **Relevant medical History** |
|  |
| **Current treating General Practitioner**  |
| Doctors Name  |  | Clinic Name |  |
| Address  |  | Phone Number  |  |
| **Psychiatric Services**  |
| Psychiatrist Name  |  | Clinic Name  |  |
| Address |  | Phone Number  |  |
| **Current Paediatrician** |
| Paediatrician Name  |  | Clinic Name  |  |
| Address |  | Phone Number  |  |
| **Primary Reason for Referral** |
|  |
| **Referrer Details** |
| Referrer Name  |  | Contact No. |  |
| Email Address |  | Company Name  |  |

|  |
| --- |
| **OFFICE USE ONLY** |
| Date referral Received  |  | Priority Level  |  🞎 CAT-1 🞎 CAT-2 🞎 CAT-3  |
| First Contact date  |  | Intake Worker  |  |