|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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 |  |