

**TYSS MENTAL HEALTH SERVICE REFERRAL FORM**

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| **PLEASE COMPLETE THIS FORM AND FORWARD TO:** **EMAIL:** YOUTHMENTALHEALTH@TAIHS.NET.AU | **FOR MORE DETAILS PHONE:** 47594048/ 0448558990**ADDRESS**: 10-16 PEEL STREET GARBUTTACCESS VIA LONERGANNE STREET |
| TYSS Mental Health AdminGarbutt Primary School |
| **REFERRERS INFORMATION**  |
| Completed Date:  | Referral completed by:  |
| Relationship to young person: |
| Contact Number:  | Email:  |
| Referred on a Mental Health Plan: [ ]  Yes [ ]  No | NDIS Participant: [ ]  Yes [ ]  No |
| **YOUNG PERSONS PERSONAL DETAILS**  |
| Given Name:  | Family Name:  |
| Identified Gender: [ ]  Female [ ]  Male ☐ Other Identifier: |  DOB: | Current Age:  |
| **Cultural Identity** | ☐ Aboriginal ☐ Both Aboriginal & Torres Strait Islander☐ Australian, neither Aboriginal nor Torres Strait Islander | ☐ Torres Strait Islander ☐ Australian South Sea Islander ☐ Other :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| **Relationship Status:**  | [ ]  Single[ ]  Married  | [ ]  De-facto [ ]  Divorced  | [ ]  Never married  |
| **Source of Income:**  | [ ]  Centrelink  | [ ]  Employment  | [ ]  Other – Please specify |
| **YOUNG PERSON’S CONTACT DETAILS**  |
| Phone Number:  | Email:  |
| Primary Address:  | Lives With:  |
| Homelessness Flag: [ ]   | Postcode: |
| Alternative Phone Number: Phone Number belongs to: |
| Alternative Address:  Belongs to: |
| **EMERGENCY CONTACT DETAILS**  |
| Name:  |
| Phone Number:  | Relationship to young Person:  |
| **MEDICAL DETAILS** |
| [ ]  Has a mental health professional ever diagnosed you with anything? [ ]  Yes [ ]  No [ ]  Unsure If Selected Yes, please provide diagnoses: |
| [ ]  Have you ever been prescribed medication for mental health concerns? [ ]  Yes [ ]  No [ ]  UnsureIf yes, what medication/s: |
| Are you taking the medication/s correctly as prescribed by your Doctor? [ ]  Yes [ ]  No [ ]  UnsureIf no, why not: |
| Do you have any health issues? (e.g., Asthma, allergies, diabetes) [ ]  Yes [ ]  No [ ]  UnsureDetails: |
| Are you taking any medication for the above health issues? [ ]  Yes [ ]  No [ ]  UnsureIf yes, what medication/s?  |
| **PRIMARY REASON FOR REFERRAL**  |
| [ ]  Aggression  | [ ]  Self-Harm  | [ ]  Lack of Motivation  |
| [ ]  Suicidal thoughts / Attempts | [ ]  Lack of engagement in family and social life  | [ ]  Substance use, please list substances: |
| [ ]  Behaviour | [ ]  Moods | [ ]  Family dysfunction |
| [ ]  Thoughts | [ ]  Exposure to Domestic Violence  | [ ]  Trauma  |
| [ ]  Other  |
| ***Please elaborate on concerns – why are you wanting a referral to TYSS Mental Health:*** |

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| **Have you, the young person, ever been referred elsewhere for mental health and/or AOD services?**  |
| [ ]  Act for Kids  | [ ]  EVOLVE (Kirwan Hospital)  | [ ]  TAIHS Mental Health  |
| [ ]  Aspire (Uniting care)  | [ ]  Headspace  | [ ]  Beyond Blue  |
| [ ]  Lives Lived Well  | [ ]  CYMHS (Kirwan Hospital) | [ ]  Relationships Australia  |
| [ ]  Other  |
| If not, why not? |
| If yes, When: [ ]  less than 3 months ago [ ]  3 – 6 months ago [ ]  More than a year ago If less than 3 months ago, what is the status of your referral? Have you ever engaged with another mental health service? [ ]  Yes [ ]  No |

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| **CONSENT**  |
| **Do you, the young person consent to this referral being made to TYSS Mental Health Service?** [ ]  **Yes** [ ]  **No**  |
| **I am aware that by signing this referral,** [ ]  My information will be shared with TYSS Mental Health so that a service can be provided. [ ]  I have the right to privacy and confidentiality.[ ]  I can ask to see the personal information recorded about me. [ ]  Information about me will not be shared with others without my consent (except for duty of care reasons or as required by law).[ ]  I can withdraw my consent at any time.[ ]  I understand that my information will be stored on a online, secure client information system which is only accessible by TYSS Mental Health staff[ ]  Each party is consenting to non-identifying information being provided to relevant department for research, reporting and statistical purposes only. Non-identifying information means that your personal details are not provided. **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referrer’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Young Person’ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Guardian’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**Notes:**

* TYSS Mental Health Service is unable to provide transportation to and from appointments.
* To remain fair and equitable to all clients, appointments cannot be held
* We are unable to continue to offer appointments to young people who cancel or do not attend without sufficient notice , after more than three times.
	+ We will contact you to discuss the barriers to you attending
* All young persons MUST consent to the referral being completed and sent to TYSS Mental Health Service.
* Parental / Guardian consent is required for ALL young people referred under the age of 16.