

**TYSS MENTAL HEALTH SERVICE REFERRAL FORM**

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| **PLEASE COMPLETE THIS FORM AND FORWARD TO:**  **EMAIL:** [YOUTHMENTALHEALTH@TAIHS.NET.AU](mailto:youthmentalhealth@taihs.net.au) | | | **FOR MORE DETAILS PHONE:** 47594048/ 0448558990  **ADDRESS**: 10-16 PEEL STREET GARBUTT  ACCESS VIA LONERGANNE STREET | | |
| TYSS Mental Health Admin  Garbutt 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  Unsure  If yes, what medication/s: | | | | | |
| Are you taking the medication/s correctly as prescribed by your Doctor?  Yes  No  Unsure  If no, why not: | | | | | |
| Do you have any health issues? (e.g., Asthma, allergies, diabetes)  Yes  No  Unsure  Details: | | | | | |
| Are you taking any medication for the above health issues?  Yes  No  Unsure  If 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.