

# CCVT FMHSS - Referral Form

**OFFICE USE ONLY**

Allocated to: \_\_\_\_\_

Date: \_\_\_\_\_

**\* Shaded fields are mandatory**

**Child \ Young Person Details 1**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: \_\_\_\_\_

Schools attended: \_\_\_\_\_

Is there a disability or a diagnosis?  
\_\_\_\_\_

Living Arrangements  
\_\_\_\_\_

Relationship to adult family member? \_\_\_\_\_

**Child \ Young Person Details 2**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: \_\_\_\_\_

Schools attended: \_\_\_\_\_

Is there a disability or a diagnosis?  
\_\_\_\_\_

Living Arrangements  
\_\_\_\_\_

Relationship to adult family member? \_\_\_\_\_

**Child \ Young Person Details 3**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: \_\_\_\_\_

Schools attended: \_\_\_\_\_

Is there a disability or a diagnosis?  
\_\_\_\_\_

Living Arrangements  
\_\_\_\_\_

Relationship to adult family member? \_\_\_\_\_

## Child \ Young Person Details 4

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: \_\_\_\_\_

School/s attended: \_\_\_\_\_

Is there a disability or a diagnosis?

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Living Arrangements

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Relationship to adult family member? \_\_\_\_\_

## Adult Family Member's Details

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: \_\_\_\_\_

- Aboriginal - Torres Strait Islander Cultural background \_\_\_\_\_

Language spoken: \_\_\_\_\_ Interpreter required? - Yes - No

Phone: \_\_\_\_\_

Home address: \_\_\_\_\_

Postal address: \_\_\_\_\_

Email address: \_\_\_\_\_

Relationship to client: \_\_\_\_\_

## Eligibility Questions

Does the referral concern a child or young person between 0 and 18 years? - Yes - No

Is there at least one adult family member or carer willing to work with the child or young person and the service? - Yes - No

Is that person the person listed above? - Yes - No

If no, who is that person? Please provide name, relationship and contact details

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Is there a presenting issue for the child or young person which may increase their risk of having poor mental health outcomes later in life? - Yes - No

Current Child Protection involvement? - Yes - No

Under Care and Protection Order? - Yes - No

If Yes, please list and clarify

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Transitioning to out of home care? - Yes - No

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## Presenting Issues

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Are there issues within the family that may be impacting on the child's / young person's wellbeing (eg Unstable accommodation, mental health issues, domestic violence, misuse of drugs or alcohol?)

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What does the referrer want the child and family to achieve by working with the FMHSS program?

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### Referral Source

- Self      Or      - Organisation

Organisation: \_\_\_\_\_

Name: \_\_\_\_\_

Phone Details: \_\_\_\_\_

Date: \_\_\_\_\_

Email address: \_\_\_\_\_

Role with Client: \_\_\_\_\_

- Consent to Share Information Form has been signed by the client and a copy attached to this referral

- Verbal consent to register personal information stored under privacy and confidentiality requirements