CCVT FMHSS - **Referral Form**

Ballarat Office
4-6 Peel Street Nth, Ballarat VIC 3350 | **T**: (03) 5337 8999 | **E:** FMHSS.Ballarat@catholiccarevic.org.au

For further information please contact an FMHSS practitioner.

OFFICE USE ONLY

Allocated to: _____ Date: _____

*** Shaded fields are mandatory**

Child \ Young Person Details 1

Name: _____ DOB: _____ Gender: _____

School\s attended: _____

Is there a disability or a diagnosis?

_____

Living Arrangements

_____

Relationship to adult family member? _____

Child \ Young Person Details 2

Name: _____ DOB: _____ Gender: _____

School\s attended: _____

Is there a disability or a diagnosis?

_____

Living Arrangements

_____

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

Transitioning to out of home care?	☐ Yes	☐ No

Presenting Issues

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?)

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

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