

Child & Family Wellbeing Service Referral Form

TeamHEALTH actively promotes and supports an inclusive and diverse culture. We welcome all people, regardless of age, gender, race, ability, sexual orientation, faith, religion and all other identities represented in our community.

Our Child and Family Wellbeing Service offers free, early intervention, one-on-one and group support for children and young people aged 0-18 across The Top End, including Darwin, Palmerston, Litchfield and surrounding communities: the Big Rivers region, including Katherine and surrounding communities and Gunbalanya.

Primary Caregiver's Details

Caregiver's Name: _____ Preferred Name: _____

Date of Birth: _____ Country of Birth: _____

Relationship to Participant(s): _____

Gender Identity: ☐ Woman ☐ Man ☐ Non-binary

☐ Different term – please specify: _____

Pronouns (optional): _____

Address: _____

Email Address: _____ Phone Number: _____

Preferred language: _____

(The language the caregiver feels most comfortable using).

Interpreter needed? ☐ No ☐ Yes If yes, what language? _____

Any other language or communication supports needed? ☐ No ☐ Yes

If yes, please describe: _____

(For example: Auslan, large print, a communication device, or a support person)

Is the caregiver of Aboriginal and/or Torres Strait Islander origin? ☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander

(Select both "Yes" options, if this applies to you).

Cultural identity (optional): _____

(How would you describe your cultural identity or background? For example, your heritage, community or cultural group?)

Formal Diagnoses (Mental Health / Physical) ☐ None ☐ Yes, specify: _____

Participants' Details

Child/Young Person 1 Name: _____

Is the participant of Aboriginal and/or Torres Strait Islander origin? ☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander

(Select both "Yes" options, if this applies to you).

Cultural identity (optional): _____

(How would you describe your cultural identity or background? For example, your heritage, community or cultural group?)

Gender Identity: _____ Date of Birth: _____

(How the child or young person identifies, or is described by their caregiver)

Pronouns (optional): _____

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Please detail any formal or suspected diagnoses, individual support needs and/or key areas of concern?

Child/Young Person 2 Name: _____

Is the participant of Aboriginal and/or Torres Strait Islander origin? ☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander

(Select both "Yes" options, if this applies to you).

Cultural identity (optional): _____

(How would you describe your cultural identity or background? For example, your heritage, community or cultural group?)

Gender Identity: _____ Date of Birth: _____

(How the child or young person identifies, or is described by their caregiver)

Pronouns (optional): _____

Please detail any formal or suspected diagnoses, individual support needs and/or key areas of concern?

Child/Young Person 3 Name: _____

Is the participant of Aboriginal and/or Torres Strait Islander origin? ☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander

(Select both "Yes" options, if this applies to you).

Cultural identity (optional): _____

(How would you describe your cultural identity or background? For example, your heritage, community or cultural group?)

Gender Identity: _____ Date of Birth: _____

(How the child or young person identifies, or is described by their caregiver)

Pronouns (optional): _____

Please detail any formal or suspected diagnoses, individual support needs and/or key areas of concern?

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Family situation/key concerns:

Source of information (can select more than one option):

- ☐ Participant
 ☐ Referrer
 ☐ Clinical staff
 ☐ Carer or guardian
 ☐ TeamHEALTH worker
 ☐ Other, please specify:

Risk Assessment (Referrer to complete)

TeamHEALTH requires a brief risk assessment to ensure that we understand how to keep our staff, participants and community safe. If you need assistance filling out a risk assessment, please call us on the number below.

Family and participant risk factors <i>If selecting "yes" to any of the below, please expand on or attach relevant information/documentation.</i>	Caregiver	Child 1	Child 2	Child 3
History of suicide attempt/s or current suicide ideation (e.g. chronic, recent)	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Please provide further details:				
History of self-harm (e.g. chronic, recent)	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Please provide further details:				
Recent traumatic life event (e.g. assault, bereavement, legal concerns, family violence, homelessness etc.)	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
Please provide further details:				
Historical or Current drugs or alcohol use	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
If yes, please provide details of substances and any history of rehab or AOD counselling:				
Forensic history (including DVO, custodial orders, recent incarceration, upcoming legal matters, parole or bail conditions)	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes

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Risk Assessment (Referrer to complete)

Please provide further details:

Recent incident involving aggression/violence/weapon use or possession, (incl. family member with DVO or aggressive behaviour etc.)

☐ No ☐ Yes

☐ No ☐ Yes

☐ No ☐ Yes

☐ No ☐ Yes

Please provide further details:

Expressing intent to harm others/preoccupation/hallucinations with violent or paranoid themes/ideas

☐ No ☐ Yes

☐ No ☐ Yes

☐ No ☐ Yes

☐ No ☐ Yes

Please provide further details:

Inappropriate sexual behaviour

☐ No ☐ Yes

☐ No ☐ Yes

☐ No ☐ Yes

☐ No ☐ Yes

Please list serious events or presenting behaviours:

Reduced ability to self-control/difficulties with emotional regulation etc.

☐ No ☐ Yes

☐ No ☐ Yes

☐ No ☐ Yes

☐ No ☐ Yes

Please provide further details:

Known prejudices – ethnic, religions, (including prejudices that emerge as part of psychosis)

☐ No ☐ Yes

☐ No ☐ Yes

☐ No ☐ Yes

☐ No ☐ Yes

Please provide further details:

Vulnerabilities (financial abuse, trauma history, relational/sexual)

☐ No ☐ Yes

☐ No ☐ Yes

☐ No ☐ Yes

☐ No ☐ Yes

Please provide further details:

Recommendations to support the safety and comfort of the person in our service (e.g. safety plans, coping strategies, skills or strengths):

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Details relating to any identified risks and/or other identified risk factors:

Protective factors (e.g. friends, family, professional relationships, culture, faith, hobbies, study, employment etc.)

Person Referring: _____

Relationship to Participant: _____

Phone number: _____

Email: _____

Referrer's Signature: _____ Date: _____

Consent

TeamHEALTH is collecting this information to set up and provide your support. We'll store it securely and only share it where it's needed to arrange or deliver that support. You can ask to see or correct your information, or withdraw your consent, at any time. This won't affect the support you receive.

☐ I consent to this referral

Your information is handled in line with the *Privacy Act 1988 (Commonwealth)*, the *Australian Privacy Principles*, and the *NT Information Act*.

AND

Signature of Primary Caregiver

Signature of Participant (if aged 16+)

Date

In the absence of written consent, verbal consent was gained ☐ No ☐ Yes

Completing this Form

- Please call TeamHEALTH on **1300 780 081** if you need any assistance completing this form.
- Send the completed form to: teamhealth@teamhealth.asn.au.
- TeamHEALTH will contact the participant or Public Guardian within three working days of receiving this form.

Thank you for your referral!