Child & Family Wellbeing Service Referral

The Child & Family Wellbeing Service supports children/young person(s) aged 0-18 years. We work alongside families and children/young person(s) who are affected by or showing early signs of mental health concerns. Using a person-centred approach, strengths are identified and built upon to work towards goals and enhance wellbeing.

Support is available within Palmerston/Litchfield, Katherine and Gunbalanya Community.

Primary Caregiver's Details

Caregiver's Name _____ Date of Birth _____

Relationship to Participants _____ Gender ☐ Male ☐ Female ☐ Non-binary ☐ Other

Email Address _____ Phone Number _____

Address _____

Country of Birth _____ Language at Home _____

Ancestry ☐ Aboriginal ☐ Torres Strait Islander ☐ Non-Indigenous ☐ Not Stated Interpreter? ☐ No ☐ Yes

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

Participants' Details

Child/Young Person 1 - Full Name _____

Gender ☐ Male ☐ Female ☐ Non-binary ☐ Other DOB _____

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

Child/Young Person 2 - Full Name _____

Gender ☐ Male ☐ Female ☐ Non-binary ☐ Other DOB _____

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

Child/Young Person 3 - Full Name _____

Gender ☐ Male ☐ Female ☐ Non-binary ☐ Other DOB _____

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

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Family situation/key concerns:

Brief Risk Assessment – Referrer to complete for each individual referred (incl. parent/carer)

Source of Information (can select more than one option)

☐ Participant ☐ Referrer ☐ Clinical staff ☐ Carer or guardian ☐ TeamHEALTH worker

☐ Other, please specify

Family and Participant Risk Factors *(If answering 'yes' please provide further details)*

Detail individual name/initials in each column as required	**Parent/Carer** _____	**Child 1** _____	**Child 2** _____	**Child 3** _____
History of suicide attempt/s or current suicide ideation	☐ No ☐Yes	☐ No ☐Yes	☐ No ☐Yes	☐ No ☐Yes
Recent traumatic life event	☐ No ☐Yes	☐ No ☐Yes	☐ No ☐Yes	☐ No ☐Yes
Current misuse of drugs or alcohol	☐ No ☐Yes	☐ No ☐Yes	☐ No ☐Yes	☐ No ☐Yes
Forensic history	☐ No ☐Yes	☐ No ☐Yes	☐ No ☐Yes	☐ No ☐Yes
Recent incident involving aggression/violence, incl. family member with DVO or aggressive behaviour etc.	☐ No ☐Yes	☐ No ☐Yes	☐ No ☐Yes	☐ No ☐Yes
Known use of weapons	☐ No ☐Yes	☐ No ☐Yes	☐ No ☐Yes	☐ No ☐Yes
Expressing intent to harm others	☐ No ☐Yes	☐ No ☐Yes	☐ No ☐Yes	☐ No ☐Yes
Preoccupation/hallucinations with violent/paranoid themes/ideas	☐ No ☐Yes	☐ No ☐Yes	☐ No ☐Yes	☐ No ☐Yes
Inappropriate sexual behaviour	☐ No ☐Yes	☐ No ☐Yes	☐ No ☐Yes	☐ No ☐Yes
Reduced ability to self-control/self-regulate	☐ No ☐Yes	☐ No ☐Yes	☐ No ☐Yes	☐ No ☐Yes
Major physical disability/illness (including infectious disease)	☐ No ☐Yes	☐ No ☐Yes	☐ No ☐Yes	☐ No ☐Yes
Known prejudices – ethnic, religions, other:	☐ No ☐Yes	☐ No ☐Yes	☐ No ☐Yes	☐ No ☐Yes
Issues with compliance eg appointments, medication. If yes, please detail:	☐ No ☐Yes	☐ No ☐Yes	☐ No ☐Yes	☐ No ☐Yes

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

Protective Factors

Person Referring _____ Relationship to Family _____

Email _____ Phone _____

Referrer's Signature Date

Consent

I consent to this referral. I understand that this information will be stored on the TeamHEALTH system and may be used for reporting and audit purposes. I understand and consent that as part of reporting obligations TeamHEALTH may be required to share information with Department of Social Services (DSS), state and territory governments, or another agency contracted to DSS, for verification of eligibility, monitoring of outcomes, IT support, reporting, research and statistical purposes. This may include identifying information about me or my child/ young person(s), including mine and my child/young person(s) full name, date of birth, address, disability status, ancestry, country of birth and main language spoken at home as well as other de-identified information. I understand that no details about the content of sessions will be included in this reporting. I can request that a pseudonym be used if this is my preference. I understand and consent that Department of Social Services (DSS), state and territory governments, or another agency contracted to DSS, for verification of eligibility, monitoring of outcomes, IT support, reporting, research and statistical purposes. I am aware that Child and Family Programs at TeamHEALTH are funded by the Department of Social Services through the Family Mental Health Support Service. I understand that the Department of Social Services Privacy Agreement can be accessed at https://www.dss.gov.au/privacy-policy or I can request a copy from TeamHEALTH.

Signature of Primary Caregiver AND 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: cfwsreferrals@teamhealth.asn.au
- TeamHEALTH will contact the primary caregiver within two working days of receiving this form.

Thank you for your referral

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