MonashHealth

Patient UR:
Patient Name:
DOB:
Sex:
Address:

Clear/Reset Form

YOUTH AND FAMILY REFERRAL FORM

(Community Clinical Handover Tool, can be used if internal to Monash Health)

Date of referral:

***Please fill in as much detail as possible/appropriate**

Client Details

Aboriginal or Torres Strait Islander: Yes ☐ No ☐ Unsure ☐

Name: DOB:

Preferred Name if Different from above:

Gender Assigned at Birth: Male ☐ Female ☐

Address: Post Code:

Home Phone: Mobile Number:

Email Address:

Is Telehealth appropriate? Yes ☐ No ☐ Unsure ☐

Medicare Details: Expiry: Health Card Details:

Country of Birth:

Refugee Status: Yes ☐ No ☐

Language spoken at home:

Other spoken languages:

Is an interpreter required? Yes ☐ No ☐

Does the client have a GP? Yes ☐ No ☐

Gender Identity and Orientation

Self-Described Gender Identity: Pronouns:

Self-Described Sexual Orientation:

Comments:

GP DETAILS:

Doctors Name:

Clinics Name:

Address:

Phone Number:

Next Of Kin/Emergency Contact

Name: Relationship:

Address:

Post Code: Phone Number:

REFERRER DETAILS

Referral Source: ☐ Self: ☐ Family/Friend: ☐ Service Provider:

Referrer Name: Phone contact:

Organisation: Role:

Email:

SAFETY / BEHAVIOUR / CRISIS MANAGEMENT

Allergy Alerts:

Are there any safety concerns that we need to be aware of?

Are there any current crisis management plans/ safety plans behaviour management strategies for the client?

(Please attach if appropriate or tell us to look at medical record)

RISK OF FALLS / PRESSURE INURY (If unsure this will be assessed on first appointment)

Any history of pressure injury, localised injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, shear and/or friction, or a combination of these factors?

Yes ☐ No ☐

When completing day to day tasks, walking, turning, domestic duties is there?

No unsteadiness ☐ Minimal unsteadiness ☐ Moderate Unsteadiness ☐

Consistently ☐ Unsteady ☐

Has there been any falls in the last 12 months?

None 1 ☐ 2 ☐ 3 or more ☐

If any falls recorded or unsteadiness is there any assistance required to access in programs?

Does the client consent to a Physiotherapist or Occupational Therapy Referral to address any concerns?

Yes ☐ No ☐

MENTAL HEALTH SCREENING (If unsure this will be assessed on first appointment)

During the past month, have you been bothered by feeling down, depressed or hopeless?

Yes ☐ No ☐ Comment:

During the past month, have you often been bothered by little interest or pleasure in doing things?

Yes ☐ No ☐ Comment:

Does mental health currently impact on safety or anyone living with or cared for by the service users?

Yes ☐ No ☐ Comment:

If yes to one or more of the above questions consider a referral to counselling or a therapeutic interventions such as music therapy or exercise physiology which may help to alleviate distress and promote engagement in counselling.

NURTITION SCREENING: (If unsure this will be assessed on first appointment)

Does the client struggle to access to food due to budgeting, skills or knowledge.

Yes ☐ No ☐ Comment:

Does the client eat less than twice per day due to dieting, decreased appetite, skipping meals or to influence body shape or size?

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Yes ☐ No ☐ Comment:

Has the client *unintentionally* lost or gained more than 5kg in the last 6months?

Yes ☐ No ☐ Comment:

If yes to one or more of the above questions consider a referral to Dietetics.

HEALTH CONCERNS/ DIAGNOSES/ CURRENT ISSUES FOR CONCERN / PURPOSE AND REASON FOR REFERRAL

MonashHealth

SERVICE REQUIRED

(Refer to Youth & Family Services flyer for information on services).

Do you have a current NDIS plan for any service listed below?

Yes ☐ No ☐ Comment:

If yes do not refer for that service.

Please place numerical value in the box starting at 1 to rank order of preference.
(just number the services you require. You don't have to put a number in each box)

Counselling	Care Co-ordination
Sexual Health	Health Assessment
Exercise Physiology	Communication

Dietetics - our service cannot accept people with a current eating disorder

Music Therapy

** All services are for people aged 15 - 25 year olds*

ANY OTHER SERVICES CURRENTLY PROVIDING SUPPORT

Agency:	Contact:	PH:
Agency:	Contact:	PH:
Agency:	Contact:	PH:

CLIENT CONSENT

Do you have the client's consent for this referral? (Where possible, please have the client sign below)

Yes ☐ No ☐ Comment:

If under 16 years of age are the parents/carers aware of this referral?

Yes ☐ No ☐ Comment:

Client signature: Date:

Referrer's signature: Date:.

MonashHealth

Please email completed referral and/or any enquiries to: youthtriage@monashhealth.org

Will we respond within 24 hours of receipt.

Thank-you for referring

Youth Triage Team

Youth & Family Services / Monash Health Community

MonashHealth Community

Triage Use Only

☐ Rights and Responsibilities sent to client or guardian on acceptance of referral.