Monash Health

Youth and Family Referral Form (MDC Nursing)
Email completed referral and/or any enquiries.
Response within 2-3 business days of receipt.
E: chndandenongmdc@moanshhealth.org or chnseafordmdc@monashhealth.org
T: 0466 304 420, 0466 304 419, 0466 304 417

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

Date of Referral:

Client's consent for referral (signature where possible): □ Yes □ No Client's signature:

Client Details

First Name: Aboriginal or Torres Strait Islander: □ Yes □ No □ Unsure

Last Name: Refugee/Asylum Seekers Status: □ Yes □ No

Preferred Name: Country of Birth:

DOB: Is an interpreter needed? □ Yes □ No

Phone Number: Language/s spoken:

Address:

Medicare Details: Expiry: Health Card Details:

Are there in Court Orders Relating to Safety (Children's Court, Magistrates)? □ Yes □ No
If yes, our team will contact to discuss the nature of the order to ensure safety

GP details (Doctor/Clinic Name, Address, and Number):

Gender Identity and Orientation

Gender assigned at birth: □ Male □ Female Gender Identity/Sexual Orientation:

Pronouns: Additional Comments:

Next of Kin/Emergency Contact

Name: Relationship:

Contact Number:

Referral Details

Referrer Name: Referral Source: □ Self □ Family/Friend □ Service Provider

Organisation: Role:

Email: Phone Contact:

Do you have a current NDIS plan for any services listed below? *(if yes, do not refer for that service)*

□ Yes □ No Comment:

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Presenting Concerns/Reason for Referral (i.e., health issues, mental health issues, social issues, diagnoses, current medications):

Any other services currently providing support:

Agency: Role: Contact:

Agency: Role: Contact:

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)

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 intervention (i.e., music therapy or exercise physiology) which may help to alleviate distress and promote engagement in counselling.

Nutrition Screening (if unsure, this will be assessed on first appointment)

Does the client struggle to have 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? □ Yes □ No Comment:

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

□ Yes □ No Comment:

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

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Risk of Falls/Pressure Injury (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 body 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, or domestic duties, is there?

□ No unsteadiness □ Minimally unsteady

□ Moderately unsteady (supervision) □ Consistently & Severely unsteady (hands on assistance)

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?

Comment:

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

□ Yes □ No

Please email the completed referral and/or any enquiries to:
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We will respond within 2-3 business days

Thank you for referring

Triage Use Only

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