

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:

Service/Health Profession Requested – Refer to Youth & Family Services flyer for service information

(Please rank services needed starting at 1 in order of preference – You don't have to put a number for each service)

- | | | |
|--|--|--|
| <input type="checkbox"/> Counselling (Psychologist/Social Worker) | <input type="checkbox"/> Social Work | <input type="checkbox"/> Care Coordination |
| <input type="checkbox"/> Sexual Health | <input type="checkbox"/> Health Assessment | <input type="checkbox"/> Music Therapy |
| <input type="checkbox"/> Dietetics – our service cannot accept people with a current eating disorder | <input type="checkbox"/> Exercise Physiology | |

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

We will respond within 2-3 business days

Thank you for referring

Youth Triage Team

Youth & Family Services / Monash Health Community

Triage Use Only

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