

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

**Date of Referral:**

**Client/legal guardian has agreed to the referral and the sharing of their personal and health information with the health service:**  Yes  No      Client's signature (where possible):

**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:  
Email Address:      Is Telehealth appropriate?  Yes  No  Unsure  
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*  
Does the client have a GP?  Yes  No  
GP details (Doctor/Clinic Name, Address, and Number):

**Gender Identity and Orientation**

Gender assigned at birth:  Male  Female      Self-Described Gender Identity:  
Pronouns:      Self-Described Sexual Orientation:  
Additional Comments:

**Next of Kin/Emergency Contact**

Name:      Relationship:  
Contact Number:      Address:

**Referral Details**

Referrer Name:      Referral Source:  Self  Family/Friend  Service Provider  
Organisation:      Role:  
Email:      Phone Contact:  
Address:

**Does the client have a current NDIS plan for any services listed on the next page? (if yes, do not refer for that service)**  
 Yes  No  
Comment:

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

**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"/> Sexual Health  | <input type="checkbox"/> Health Assessment |
| <input type="checkbox"/> Music Therapy  | <input type="checkbox"/> Exercise Physiology  |  |
| <input type="checkbox"/> Dietetics – <i>Our service cannot accept people with a current eating disorder</i> |   |  |
| <input type="checkbox"/> Care Coordination  | – <i>As a health service, we do not accept referrals for employment and housing support</i> |  |
| <input type="checkbox"/> Social Work  |   |  |

**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.*

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**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.*

**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](mailto: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.