

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:

UR:

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DOB:

Age:

Sex:

Address:

**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.*

UR:

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DOB:

Age:

Sex:

Address:

**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.