PO Box 1062

West Leederville WA 6901

22 Blencowe Street

West Leederville WA 6007

Phone|93804660 Fax|9388 2793

Email: info@picys.org.au

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| T**o be eligible the young person must:** |  |  | **Have a number of these other issues:** |  |
|  |  |  |  |  |
| Aged between 15 - 20 (primarily 15-18) | [ ]  |  | At risk of self-harm | [ ]  |
| Seeing a MH professional or willing to see one | [ ]  |  **AND** | Suicidal ideation or attempts | [ ]  |
| Residing within the Perth metro area | [ ]  | Have a mental health illness | [ ]  |
| At risk of homelessness OR transient | [ ]  |  | Exhibit impulsive behaviours | [ ]  |
|  |  |  | Misusing alcohol and/or other drugs | [ ]  |
|  |  |  | Difficulty maintaining relationships | [ ]  |
|  |  |  | Exhibit anxiety or depressive symptoms | [ ]  |

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| --- | --- | --- | --- |
| **Name of Referrer** |       | **Contact No** |       |
| **Referring Agency** |       | **Fax No** |       |
| **Reason for Referral - why does the young person want to attend PICYS?** |
|       |
| **Client Surname** |       | **Given Name/s** |       |
| **Preferred Name/s** |       | **Alias** |       |
| **Date of Birth** |       | **Age** |       | **Country of Birth** |       |
| **Cultural Identity** |       | **Ethnicity** |        |
| **Current Address** |       |
| **Suburb** |       | **Post Code** |       | **State** |       |
| **Mobile Phone** |       | **Hospital Ward** |       |
| **Home Phone** |  |  |
| **Customer Reference No** |       | **Medicare No** |       |

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| **Is an Interpreter Required?** | Yes [ ]  No [ ]  | **Gender** |       | **Sexuality** |       | **Pronouns** |       |
| **Partner’s Name** |       | **Partner’s Phone** |       |
| **Are you pregnant?** | Yes [ ]  No [ ]  | **If yes, what is your due date?** |       |
| **Do you have children?** | Yes [ ]  No [ ]  | **If yes, please give details; name, age, sex and who cares for the child/ren** |
| **Name** | **Age** | **Sex** | **Carer** |
|       |       | Female [ ]  Male [ ]  |       |
|       |       | Female [ ]  Male [ ]  |       |
|       |       | Female [ ]  Male [ ]  |       |
|       |       | Female [ ]  Male [ ]  |       |
| **Child Protection Order?** | Yes [ ]  No [ ]  |  |
| **Have you ever been in prison?** | Yes [ ]  No [ ]  | **If yes, details** |       |
| **Have you ever been in DOA facility?** | Yes [ ]  No [ ]  | **If yes, details** |       |
| **Do you have a disability?** | Yes [ ]  No [ ]  | **If yes, details** |       |
| **Are you on the DoH wait list?** | Yes [ ]  No [ ]  | **When did you apply?** |       |
| **Are you on DoH priority listing?** | Yes [ ]  No [ ]  |  |
| **Are you on any other community housing wait list?** | Yes [ ]  No [ ]  |  |
| **If yes, what organization/when did you apply?** |       |
| **If no, do you need assistance applying for community housing/DoH?** | Yes [ ]  No [ ]  |  |
| **Emergency contact** |       | **Phone/s** |       |
| **Relationship to young person** |       |
| **Next of Kin** |       | **Phone/s** |       |
| **Carer/s** |       |
| **Relationship to young person** |       |
| **Legal guardian** |       | **Phone/s** |       |
| **Relationship to young person** |       |
| **Support Networks** |
| **Agency** | **Contact Number** | **Period Engaged** | **Support Provided** |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
| **Client’s strengths** |
| Please use this space to tell us a bit about yourself, your likes and the things you are good at.      |
| **Psychiatric history and/or family issues** |
|       |
| **Medical history** |
|       |
| **General Practitioner** |       | **Phone** |       |
| **Address** |       |
| **Past prescribed/non-prescribed medications (dose, frequency, response to)** |
|       |
| **Current prescribed/non-prescribed medications (dose, frequency, response to)** |
|       |
| **History of substance abuse; treatment history and current treatment** |
|       |
| **Current Risk Factors/Support Areas Required** |
|       |       |
|       |       |
|       |       |
|       |       |
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|       |       |
|       |       |
|       |       |
| **Has the referral been discussed with the client/parent/guardian?** | Yes [ ]  No [ ]  |
| **Referral signature** |       | **Date** |       |
| **Contact No** |       | **Office** |       |

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| --- |
| Office Use Only |
| Date Referral Received |       | Date Contacted Referrer |       |
| More Information Needed? | Yes [ ]  No [ ]  | Notify if accommodation becomes available | Yes [ ]  No [ ]  |
| Eligible for Assessment? | Yes [ ]  No [ ]  |  |

**CONSENT TO REFERRAL**

The **PICYS** PILLAR Referral form collects information to assist **PICYS** staff to help young people get access to the services they need as quickly as possible.

All information will be treated confidentially and will not be used for any other purposes than what is stated on our confidentiality statement and consent form (signed when the young person arrives for their appointment).

* I am aware that this referral is being made. I understand that I can withdraw from this referral or from the referred service at any time.
* I consent to **PICYS** obtaining relevant information from government and community-based agencies, doctors and other allied health professionals, specifically relevant to my care whilst being a client of **PICYS.**

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| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| Signed |  | Print Name |  | Date |

If the young person is under 16 years of age, authorisation should (where possible) also be provided by a parent/guardian/carer.

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|  |  |  |  |  |
| Signed |  | Print Name |  | Date |