REFERRAL PILLAR

PO Box 1062
West Leederville WA 6901
22 Blencowe Street
West Leederville WA 6007 Phone | 9388 2792
Fax | 9388 2793 Email: referrals@picys.org.au

Date of Referral	

To be eligible the young person must:			Have a number of these other issues:	
Aged between 15 and 20 (primarliy 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	☐
			Domestic violence	☐

Name of Referrer		Contact No	
Referring Agency		Email	

Reason for Referral - why does the young person wish to be case managed by PICYS? What are some of the goals they wish to achieve?

Client Surname		Given Name/s	
Preferred Name/s		Alias	
Date of Birth		Country of Birth	
Cultural Identity	Select		
Email			
Current Address			
Suburb		Post Code	Homeless: Select
Mobile Phone		Hospital Ward	
Medicare No			
Do you receive Centrelink? Select		Do you receive other income? Select	What?
Is an Interpretor required? Select		Identified Gender	Pronouns
Current Living Situation	Select	Trans or gender diverse: Select	LGBTIQA+: Select

Partner's Name		Partner's Phone	
Are you pregnant?	Select	If yes, what is your due date?	
Do you have children?	Select	If yes, please give details; name, age, sex and who cares for the child/ren	

Name	Age	Sex	Carer

Child Protection Order?	Select		
Have you ever been in prison?	Select	If yes, details	
Have you ever been in an alcohol or other drug facility?	Select	If yes, details	
Do you have a disability?	Select	If yes, details	
Are you on the Dept of Housing wait list?	Select	When did you apply?	
Are you on DoH priority listing?	Select		
Are you on any other community housing wait list?			
If yes, what organization/when did you apply?			
If no, do you need assistance applying for community housing/Dept of Housing?			
Emergency contact		Phone/s	
Relationship to young person			
Next of Kin		Phone/s	
Relationship to young person			
Legal guardian (if applicable)		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.

Mental Health Issues 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	Give Details
☐	Suicidal ideation or behaviour	
☐	Aggressive behavior/violence	
☐	Self-harm	
☐	Lack of self care	
☐	Alcohol or drug use	
☐	Debt	
☐	Vulnerable to abuse/exploitation	
☐	Risk-taking behaviour	
☐	Legal issues	
☐	Other	

Has the referral been discussed with the client/parent/guardian?	Select		
Referral signature		Date	
Contact No		Office	

Office Use Only			
Date referral received		Date Contacted Referrer	
More Information needed?	Select	Notify if accommodation becomes available	Select
Eligible for assessment?	Select		

CONSENT TO REFERRAL

The **PICYS** HouseHold Network 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.**

- I consent to **PICYS** collecting data for the Australian Institute of Health & Welfare.

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.

Signed	Print Name	Date

SUBMIT TO PICYS