Adolescent Project Referral Form

Boab Health Services Adolescent Project is a free service to young people aged around 12 to 15 years who are experiencing issues associated with their current alcohol and/or drug use and would like support and guidance to address these issues. This service is provided as a part of the Cashless Debit Card trial support package.

Services available through this project may include:

- Drug and alcohol psychoeducation
- Individual counselling
- Group activities
- Family sessions and support
- Support accessing other services

Young people need to be aware of, and consent to, the referral and be willing to meet with a Boab Health clinician for assessment. They must also have a willing guardian or family member that can support them through promoting the young person's attendance and themselves attending some group activities or camps.

Please FAX this form to (08) 9192 7999

PLEASE NOTE: We **do not** provide crisis or acute care. If you believe the client is in crisis, or requiring immediate assistance, please contact the Kimberley Mental Health Services in Kununurra on 9166 4350.

Referral Date: _____ **Is client aware of referral?** ☐ Yes ☐ No

Referral Source: ☐ Self ☐ Doctor ☐ Friend/Family Member ☐ School ☐ Service Provider

Client Details

Name: _____ Date of Birth_____/_____/_____

Gender: ☐ Female ☐ Male ☐ Other: _____

Street Address: _____

Postal Address: _____

Contact Details: Mobile: _____ Home Phone_____

Is the young person of Aboriginal and/or Torres Strait Islander decent? (tick as appropriate)
☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, both

Who does the young person live with? _____

Education status? _____

Ability to speak English? ☐ Very Well ☐ Well ☐ Not Well ☐ Not at all

Does the young person have any of the following health conditions? (tick as appropriate)
☐ Diabetes ☐ Heart Disease ☐ Kidney Disease ☐ Epilepsy ☐ Lung Disease
☐ Asthma ☐ Low/high blood pressure ☐ Allergies: _____
☐ Other: _____

Boab Health Services Pty Ltd
Broome Office
Unit 5, 20 Hamersley Street | PO Box 1548 Broome, WA 6725
T 08 9192 7888 | F 08 9192 7999 |
Kununurra Office
Coolibah Centre, 96 Coolibah Drive | PO Box 1866 Kununurra, WA 6743
T 08 9168 2560 | F 08 9168 3305 |
reception@boabhealth.com.au | www.boabhealth.com.au | ABN: 86 105 341 866

Emergency Contact Details

Name: _____ Phone: _____

Address: _____

Relationship: _____

Does this person consent to be involved in the program? ☐ Yes ☐ No

Referrer's Details

☐ Same details as Emergency Contact

Name: _____ Organisation: _____

Position: _____

Phone: _____ Email: _____

Reason for Referral (including drug and/or alcohol use)	
Client History (relevant biological, psychological, physical and social family history)	
Risk Taking Behaviours (self-harm, suicide ideation, daily substance use amounts, aggression, self-neglect)	
Risk of Harm from Others (Please advise from whom and any current strategies or legal requirements to keep the young person safe)	

Client Consent

- A part of the referral process to Boab Health is for us to learn about you and the other services involved in your life.
- All Information we find out about you, including from yourself, will be treated confidentially, which means we will not share your information with anyone else unless you give us permission or you are at serious risk.

I am involved in the following services and I consent (give my permission) to Boab Health to obtain the relevant information from the following people:

☐ CAMHS (Child and Adolescent Mental Health Service)

☐ GP Name: _____

Practice: _____

☐ Not for Profit (e.g. Save the Children): _____

☐ School Psychologist/Chaplin/Counsellor: Name: _____

School: _____

☐ Government Service: _____

- ☐ Department of Child Protection and Family Support Name: _____
- ☐ Youth Justice Name: _____
- ☐ Police Name: _____

☐ Anyone else you can think of? _____

_____

_____

- I am aware that this referral is being made. I understand I can withdraw from Boab Health Adolescent Program at any time. ☐ Yes ☐ No
- I understand that any information collected by Boab Health is stored confidentially. I give my permission Boab Health to obtain relevant information from the people listed above ☐ Yes ☐ No

Client Signature: _____ **Client Name**: _____ **Date**: _____

Guardian Signature: _____ **Guardian Name**: _____ **Date**: _____

If you believe the client is in crisis, or requiring immediate assistance, please contact the Kimberley Mental Health Services in Kununurra 9166 4350.

If you wish to discuss this referral or interim alternative options available within the community please contact the Boab Mental Health Team Kununurra: 9168 2560