East Kimberley Youth Service Referral Form

Boab Health Services East Kimberley Youth Service provides mental health and wellbeing programs to young people aged from 12 – 25+ years. These services apply to mental health and wellbeing issues across the spectrum of ill-health and wellness.

Services available through this project may include:

- Drug and alcohol psychoeducation
- Individual counselling
- Focused Psychological Strategies
- Group activities
- Art Therapy
- 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. If under the age of 16, they must also have a willing guardian or family member that can support them and promote the young person's attendance. In consultation with the referrer and the client, the most appropriate program/s will be offered.

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 (Presenting issues including drug and/or alcohol use, mental health diagnosis, relevant medical history and include any relevant documentation)	
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)	
Requested Service (What services/treatment do you anticipate we will provide?)	

Office Use Only:					
ARP:	ABLe:	KY:	YSEP:	YHWBH:	Other:

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 Youth Service 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 Youth Service Team Kununurra: 9168 2560

Consent for Use of Photographs & Recordings

Boab Health Services is tasked with providing information about health issues in the community and promoting public health messages.

As part of this communication role, Boab Health Services uses photos, digital images, video and audio recordings in various publications, campaigns and advertising and on websites.

Boab Health Services seeks your consent to use photos, digital images, audio or video recordings taken of you for use in these communication initiatives (the 'Agreed Purpose').

Acknowledgement and consent

I acknowledge that I:

- Am over the age of 18 years OR I am the parent/guardian of a person who is under 18 years and have the legal authority to give consent;
- Have read the contents of this form and know that I will receive a copy of it;
- Understand that Boab Health Services does not guarantee that any images or recordings will necessarily be used;
- Understand that copyright in the images or recordings will vest with Boab Health Services.

Name _____

Name of Parent Guardian (if applicable) _____

Signed: _____

Date: _____