

East Kimberley Youth Services Referral

Boab's Youth Services provides mental health and wellbeing programs to young people aged from 8 – 25+ years. These services apply to mental health and wellbeing issues across the spectrum of ill-health and wellness, while including fun and engaging activities such as art therapy, school holiday programs and back to country trips.

Should you require more urgent assistance, please consider the following services;

Crisis Support Numbers

- RuralLink: After hours mental health service staffed by experienced community mental health professionals. Free call 1800 552 002
- Suicide Call Back Service: 1300 659 467
- Crisis Care WA: (08) 9233 1111, country free call 1800 199 008

- Lifeline: 13 11 14
- Samaritans: Free call 1800 198 313
- Men's Line: 1300 789 978
- Beyond Blue: 1300 224 636
- Kids Help Line: Free call 1800 551 800
- Alcohol and Drug Information Service: Free call 1800 198 024



BROOME HOSPITAL
Robinson Street, Broome
Phone: 9194 2222

HALLS CREEK HOSPITAL
Roberta Ave, Halls Creek
Phone: 9168 9222

DERBY HOSPITAL
Clarendon Street, Derby
Phone: 9193 3333

KUNUNURRA HOSPITAL
Coolibah Drive, Kununurra
Phone: 9166 4222

FITZROY CROSSING HOSPITAL
Fallon Rd, Fitzroy Crossing
Phone: 9166 1777

WYNDHAM HOSPITAL
Minderoo Street, Wyndham
Phone: 9161 0222

Referral Date:

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

If not self-referred, please provide further information:

Referrer Name:

Phone:

Fax:

Email:

Postal address to receive client correspondence:

Client name:

Date of Birth:

Is this an approximate? ☐

Gender: ☐ Male ☐ Female ☐ Other ☐ Unspecified

ATSI status: ☐ Aboriginal ☐ Torres Strait Islander ☐ Neither

Country of Birth:

Primary language:

English proficiency: ☐ Not at all, ☐ Not well, ☐ Well, ☐ Very Well

Who does the young person live with?

Residential Address:

Are there any other alternate addresses that the young person resides at? ☐ Yes ☐ No

Alternate Residential Address/s:

Postal Address:

Phone:

Mobile:

Work Phone:

Does the young person currently attend school: ☐ Yes ☐ Sometimes ☐ No

Carer Details &/or emergency contacts:

Other agencies involved in client care:

Which program are you wanting to refer into?

- ☐ Youth Support: Based in Kununurra this program provides general counselling and art therapy to 11-18 year olds. Young person must be enrolled in school (does not need to be attending) and requires a GP referral.
- ☐ Youth Engagement: Based in Wyndham this program provides individual and group support to young people aged 8 – 18 years old. Young people can receive individual support along with psycho education on drug and alcohol, health and well-being and anger management. A key focus of the program is to work address barriers that lead to low school engagement and increase attendance.
- ☐ ABLe Program: Based in Wyndham, this program provides individual and group support, advocacy and case management to people impacted by the implementation of the cashless debit card aged 16+.

What is the reason for the referral?

What are the young person's motivations and goals?

Please provide some history on the client, their family history, social supports and cultural factors:

Risk:

Please list any risk taking behaviours:

Please note any risks of self-harm, harm to others, any substances use, housing or legal issues:

BEFORE SUBMITTING THE REFERRAL PLEASE ENSURE;

- ☐ Client and carer/guardian has consented to the referral and has agreed for us to contact them for an appointment.
- ☐ The referral form above has been completed in its entirety.
- ☐ Client consents as attached below have been completed and re-attached.

MMex: bhsmht@mmex.gsmhn.com.au

Fax: (08) 9192 7999

Email: reception@boabhealth.com.au

Mental Health Team – Child and Youth Client Consent

I, (Name) _____ Date of Birth _____

Parent/Guardian (if applicable): _____

understand that 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 and stored confidentially, which means we will not share your information with anyone else unless you give us permission or you are at serious risk.

I give permission for sharing of my personal information in respect of my care and/or attendance, between the Boab Mental Health Team and:

☐ My local GP: _____ Practice: _____

☐ Child & Adolescent Mental Health Service (CAMHS): _____

☐ School Psychologist / Chaplin / Counsellor: _____

☐ Other Service Provider: _____

I also understand that details about me such as date of birth, gender and types of services I use, but not my identifiable details, like my name, address or Medicare number to be shared with:

☒ Department of Health / Social Services to meet our funding requirements and for purposes designed to improve mental health services in Australia.

Boab Health Services is committed to providing you with the highest level of service and confidentiality, and this includes protecting your privacy. Boab Health Services are bound by the Commonwealth Privacy Act 1988 and the Privacy Amendment (Private Sector) Act 2000, which outlines the principles concerning the protection of your personal information.

This authority is valid for 12 months from the date signed, but can be withdrawn at any time and will automatically expire when services are finalised by either you, or the Boab Mental Health Team.

Clients Signature: _____ Date: _____

Guardians Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Consent for Use of Photographs & Recordings

Boab Health Services provides information about primary health care in the community and promotes public health messages.

As part of this communication role, Boab Health Services uses photos, digital images, video and audio recordings in various publications including social media pages, print publications, advertising and on our website.

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: