

West Kimberley Child Mental Health Referral

Boab's Child Mental Health Service provides therapy and support to children ages 0-12 years and their families to address common mental health issues, in Broome.

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 Organisation:

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

Medicare No:

Index:

Expiry Date:

Does the client have a current GP Mental Health Care plan: ☐ Yes ☐ No ☐ No, but can be requested.

Who does the child live with?

Residential Address:

Postal Address:

Phone:

Mobile:

Work Phone:

Carer Details &/or emergency contacts:

Other agencies involved in the child's care:

What is the principle diagnosis for the reason of referral:

Is there a secondary diagnosis:

Please indicate the medication (if any) the client is currently taking:

☐ Antipsychotics, ☐ Anxiolytics, ☐ Hypnotics/Sedatives, ☐ Antidepressants, ☐ Psychostimulants/Nootropics

Mental Health Examination:

What are the presenting issues?:

What are the client's motivations and goals?

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

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.
- ☐ GPMHCP and any other applicable documents have been attached.

Once completed, please direct to Boab's Mental Health Team –

MMex: bhsmht@mmex.gsmhn.com.au

Fax: (08) 9192 7999

Email: reception@boabhealth.com.au