MonashHealth

MONASH HEALTH FaPMI PROGRAM
ALL PROGRAMS REFERRAL FORM 2018

Please tick which program/s you are referring the child/ family to:

☐ CHAMPS After School Program ☐ CHAMPS Martial Arts as Therapy program (MAT)

☐ Space4Us program

DATE OF REFERRAL: _____

Child's Information

Child's name: _____ M / F Age D.O.B. / /

Current Address: _____ Postcode: _____

Home Tel. No. _____ Mobile phone No. _____

Living with: _____

Aboriginal/ Torres Strait Islander: Y / N Ethnicity & Country of Origin: _____

Language spoken: English Y/N Other? Specify: _____

School: _____ Education level: _____

Child Worker/ school counsellor (if applicable):_____

Child's Diagnosis (if applicable): _____ UR number (if applicable or known)
_____

Parent/Carer Information.

1. Name (Primary carer): _____ M / F D.O.B. / /

Diagnosis (If applicable) _____ UR number (if applicable or known)
_____

Relationship to Child: _____ Language spoken: English Y/N Other? Specify: _____

Address: _____ Postcode: _____

Home Tel. No. _____ Mobile phone No. _____

Email address: _____

2. Name (2nd parent/guardian): _____ M / F D.O.B. / /

Diagnosis (If applicable) _____ UR number (if applicable or known)
_____

Relationship to Child: _____ Language spoken: English Y/N Other? Specify: _____

Address: _____ Postcode: _____

Home Tel. No. _____ Mobile phone No. _____

Email address: _____

3. Other carers name _____ Relationship to child eg Foster carer/permanent carer
_____

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Tel. No. _____ Mobile phone No. _____

Referrer's perception of the severity of impact of mental illness on family functioning:

0 1 2 3 4 5 6 7 8 9 10
No impact severely disruptive

Referrer's perception of the child's understanding of mental illness:

0 1 2 3 4 5 6 7 8 9 10
No understanding excellent understanding

Background Information

Reason for referral: _____

_____

_____

Brief history of child/family (e.g. relationship between parents and parent/child, recent episodes, etc.):

_____

_____

_____

Other services/family members currently supporting child and family (e.g. mental health service, counselling, etc.):

Name: _____ Phone No. _____

Nature of support: _____

_____

Name: _____ Phone No. _____

Nature of support: _____

_____

Has the child attended a CHAMPS program before? Yes/No/don't know

If yes, please give details if known: _____

Child Protection involvement? Y/N Please provide details of order _____

_____

Any other information: _____

_____

_____

<u>Worker information</u>

Name of referring worker: _____ Name of Agency _____

Agency Address: _____ Postcode: _____

Tel. No.'s _____Email address:_____

Please return to: FaPMI Coordinator: natalie.papps@monashhealth.org

This referral has been discussed with Parent/s or guardian on Date: / / and consent has been given to share information between Monash Health and other organisations involved in the provision of CHAMPS groups. The parent is aware that the FaPMI coordinator will be calling to discuss the program further.

Referrer's signature _____ Date_____