

# Referral Form: Child and Adolescent (Aged 0 – 17)

## PLEASE USE THIS FORM TO REFER A PERSON AGED UNDER 18 YEARS TO FOUNDATION HOUSE

Please send a completed copy of this form to Foundation House via:

email: [referrals@foundationhouse.org.au](mailto:referrals@foundationhouse.org.au) OR fax: 03 9277 7871

For more information on making a referral please visit [this link](#) or contact us on 03 9389 8900.

**We appreciate you completing as much information as you can. Sections in green *must* be completed.**

You will be contacted via email or phone within five (5) working days after we receive your referral.

Date of referral (dd/mm/yyyy)

## WHO WE WORK WITH

Please confirm the person you are referring meets all of the following criteria

- Refugee or refugee-like background, including people seeking asylum
- Pre-arrival history of refugee-related torture or other traumatic events or is an immediate family member
- Psychological and/or psychosocial difficulties associated with their refugee-related torture/trauma history

## CONSENT

Does the young person's parent/guardian consent to this referral to Foundation House?

- Yes     No    *If No, go to next question*

If parent/guardian consent is not provided, does the young person have capacity to give independent consent?

- Yes     No    *If Yes, go to next question; if No, contact Foundation House for a pre-referral consult*

Does the young person, as a mature minor, consent to this referral to Foundation House?

- Yes     No    *If No, see below*

*Please note: relevant consent, as per above, is required for this referral to proceed*

## REFERRER DETAILS

Referring agency/organisation name

Referrer name

Title/role/position

Service type

Telephone

Mobile

Email

Suburb

State/Territory

Postcode

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## PERSON BEING REFERRED

First/preferred name/s		Family name	
Date of birth (dd/mm/yyyy)		Estimated date of birth if actual is unknown	
Has this person previously engaged with Foundation House services? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Gender identity for person being referred? <input type="checkbox"/> Man/boy <input type="checkbox"/> Woman/girl <input type="checkbox"/> Prefers to self describe as _____	
Street address			
Suburb		State/Territory	Postcode
Country of birth		Ethnicity	
Preferred language/s		<input type="checkbox"/> Check this box if an interpreter is required	
If an interpreter is required, please detail any special requirements to consider			

## PARENT(S)/GUARDIAN(S)

Please provide the name/s and relationship/s of any parent(s)/guardian(s) for the person being referred

## BEST CONTACT DETAILS

*Please note: contact at intake is via the person's parent/guardian unless they are deemed a mature minor with capacity to provide independent consent*

First/preferred name/s		Family name	
Relationship to person being referred			
Telephone/mobile		<input type="checkbox"/> Check this box if it is safe to leave a message <input type="checkbox"/> Check this box if it is safe to send a text message/SMS	
Email		<input type="checkbox"/> Check this box if it is safe to send emails	

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Country of birth	Ethnicity
Preferred language/s	<input type="checkbox"/> Check this box if an interpreter is required

If an interpreter is required, please detail any special requirements to consider

## EMERGENCY CONTACT DETAILS

Check this box if 'Emergency' and 'Best Contact Details' are the same

Please note: 'Emergency Contact Details' are required for mature minors

Full name	Relationship to person being referred
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Telephone/mobile

## MIGRATION HISTORY

When did this person arrive in Australia? (dd/mm/yyyy)	Estimated date of arrival in Australia if actual unknown
--------------------------------------------------------	----------------------------------------------------------

Please select which of the following best describes this person's migration status

- |                                                                         |                                                               |
|-------------------------------------------------------------------------|---------------------------------------------------------------|
| <input type="checkbox"/> Australian citizen                             | <input type="checkbox"/> Temporary visa holder (eg TPV, SHEV) |
| <input type="checkbox"/> Permanent resident                             | <input type="checkbox"/> Unknown                              |
| <input type="checkbox"/> Asylum seeker (includes Bridging visa holders) |                                                               |

If this person is currently in immigration detention, which type of detention are they in?

- |                                              |                                         |
|----------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Community detention | <input type="checkbox"/> Held detention |
|----------------------------------------------|-----------------------------------------|

Migration history notes

Migration stressors (eg legal proceedings, upcoming interviews, visa expiry/cancellation)

## REASON FOR REFERRAL

Please outline the main reason/s you are referring this person to Foundation House (presenting concerns)

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## SYMPTOM CHECKLIST

Select which symptoms you have observed in this person or they are known to have presented

- Persistent emotional distress (eg crying a lot, excessive worry, panic)
- Emotion regulation issues (eg acting out, limited emotional expression, anger outbursts)
- Attachment issues (eg clingy, distant, age-inappropriate separation anxiety)
- Behavioural difficulties (eg impulsivity, reckless risk taking, passivity)
- Sleep disturbance (eg nightmares, night terrors, inability to fall asleep, too little/much sleep)
- Addictive behaviour (eg AOD, excessive gaming)
- Hypervigilance (eg easily alarmed/startled, overreactive to sensory input such as noise, light etc)
- Low mood (eg sadness, low motivation, hopelessness, despair)
- Elevated mood (eg spikes in energy, hyperactivity)
- Frequent somatic pains and other physical discomfort with no explanation (eg persistent headaches)
- Cognitive difficulties (eg memory issues, concentration difficulties, poor school performance)
- Intrusive memories of traumatic events (eg recurrent nightmares and/or flashbacks)
- Social issues (eg school refusal/infrequent attendance, relationship issues with peers, parents, teachers)
- Excessively avoiding reminders of traumatic events (eg high levels of distraction, other avoidance behaviours)
- Eating and feeding issues (eg disordered or abnormal eating/feeding patterns)
- Re-enactment of traumatic events in play
- Speech/language issues (eg selective mutism, stuttering)
- Developmental delays (not reaching developmental milestones considering cultural/community expectations)
- Other \_\_\_\_\_

## MENTAL HEALTH HISTORY

Please provide any known formal diagnosis, treatments, medications and GP details

## DAILY FUNCTIONING – AS APPROPRIATE FOR AGE AND STAGE OF DEVELOPMENT

Please describe any impacts of presenting symptoms on activities of daily living including care of self/others

## HEALTH AND DEVELOPMENT

Please list any significant/chronic physical health or medical concerns

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## RISK SCREENING

Risk to self (suicide, self-harm)			Family violence		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

Risk to others (including children)			Substance use		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

Are there relevant current or historical involvements with Family Violence, Child Protection or Family Services?

Yes       No       Unknown

Are there any intervention or other relevant court orders in place?

Yes       No       Unknown

Please specify any details, supports and safety plans in place for any risk areas identified

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Please detail any other known risks not mentioned above

## OTHER SERVICES AND SUPPORTS

Please provide details of all relevant services and supports (eg Medical/Health, School/Education, Settlement)

Service name	Description	Contact details	Consent to contact	
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No

## COMMENTS AND ATTACHMENTS

Please provide any further relevant information for this referral

Foundation House is committed to protecting privacy. We collect, store and use the information that you provide us in accordance with our privacy policy, available at [www.foundationhouse.org.au](http://www.foundationhouse.org.au)