accoras
building a better you

CHILD, YOUTH & FAMILY SERVICES
EMPLOYMENT SUPPORT SERVICES
PSYCHOLOGY SERVICES
COMMUNITY EDUCATION SERVICES

Accoras Psychosocial Outreach Program (APOP) Referral and Screening Form

This service is a free mental health support service providing practical, solution-focused mental health support to children, young people and their families. Eligible participants are children and young people aged 0-12 years who have, or are at risk of, severe mental illness but who are not more appropriately supported through the NDIS.

To be eligible for our program the client must:

- Be a child or young person between 0-12 years of age and willing to participate in the program;
- Have (or be at risk of) severe mental illness that has resulted in reduced psychosocial functional capacity (e.g. significant impacts on their family and peer relationships, in their education/employment, in their ability to undertake self-care, etc);
- Have a parent or significant adult who can be proactive, and work with their child/young person within the program for optimum long-term outcomes; and
- Live within the Darling Downs and West Moreton Region.

Please confirm:

The child or young person is aware of this referral and is **willing**, **motivated** and **able** to engage with the service to overcome challenges and work towards individual goals, and the parent/carer of the child or young person has consented to this referral being made.

☐ Yes ☐ No

We will acknowledge your referral within two working days

Referral Details			
Date of referral		Contact number	
Referrer details (incl. relationship to client)			
Email address			

Child/Young Person's Details:			
Full name		Preferred name	
Primary address			
Date of birth		Gender	
Contact number/s (if appropriate)			
School attending			
Country of birth			

Main language spoken?		Is an interpreter required	☐ Yes ☐ No
Does the young person identify as a member of one of the following groups?		☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal and Torres Strait Islander ☐ Neither	
Cultural background?			
Are you aware of any orders in place? (Child Safety, custody, DVO)		☐ No ☐ Yes – details:	

Parent or Carer's Details:	
Full name/s	
Relationship/s to child or young person	
Do the parents or carers require an interpreter?	☐ No ☐ Yes - language:
Contact details:	
Mobile number	
Email address	
Primary address	

Current service involvement:		
Please list support services involved with child or family:		
Does the child / family have a current case manager? ☐ No ☐ Yes – details:	Case manager's name	
	Organisation	

Referral information:
Does the child or young person have a confirmed or suspected diagnosis? Please provide details of diagnosis and impact on functioning and wellbeing:
The child or young person is: (please expand below) ☐ Feeling stressed, anxious or worried ☐ Feeling down, sad or depressed ☐ Difficulties with peer relationships ☐ Lacking self-esteem or confidence ☐ Feeling angry or frustrated ☐ Self harm or suicidal ideations ☐ Experiencing social/family difficulties ☐ Experiencing trauma related symptoms ☐ School refusal / attendance concerns ☐ Other (please describe below) *Details:*

Current and previous services provided to young person and family:
What outcomes would you like to see as a result of us working with the child or young person?

Referrals

Email: apop@accoras.org.au
Phone: (07) 3727 5022

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