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

Family Mental Health Support Service
Referral and Screening Form

We are a free service funded by the Department of Social Services to provide early intervention support to children and young people, alongside their families, who are showing early signs of, or at risk of developing mental health concerns. To be eligible for our program the client must:

- Be a child or young person up to and including 18 years of age;
- Be willing to participate within the FMHSS program;
- Have a parent or significant adult who can be proactive, and work with the child/young person within the program to achieve optimum long-term outcomes;
- Live within the South Brisbane or Gold Coast catchment area; and
- Not be currently not under the care of the child protection system.

Please confirm:

☐ The child or young person is aware of this referral and is **willing**, **motivated** and **able** to engage with FMHSS 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.

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

Child/Young Person Details:			
Full name		Preferred name	
Primary address			
Date of birth		Gender	
Contact number/s (if appropriate)			
School attending			
Country of birth			
Cultural background			
Main language spoken		Is an interpreter required?	☐ Yes ☐ No
Does the young person identify as a member of one of the following groups?	☐ Aboriginal ☐ Aboriginal and Torres Strait Islander ☐ Torres Strait Islander ☐ Neither		
Are you aware of any orders in place? (Child Safety, custody, DVO)	☐ No ☐ Yes – details:		

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

Referral Information

Does the child or young person have a confirmed or suspected diagnosis of any physical or mental health concerns? ☐ Yes ☐ No

The child or young person is:

☐ Feeling stressed, anxious or worried
☐ Difficulties with peer relationships
☐ Feeling angry or frustrated
☐ Experiencing social/family difficulties
☐ School refusal / attendance concerns
☐ Feeling down, sad or depressed
☐ Lacking self-esteem or confidence
☐ Self harm or suicidal ideations
☐ Experiencing trauma related symptoms
☐ Other (please describe below)

Please provide further details:

Family history (current and previous services provided to child/young person and family):

Strengths of family and child/young person (what's working well)?:
What outcomes would you like to see as a result of us working with the child or young person?:

Contact Details and Referrals:

South Brisbane Referrals |
Email: you.niqueSB@accoras.org.au
Phone: (07) 3255 6555

Gold Coast Referrals
Email: you.niqueGC@accoras.org.au
Phone: (07) 5679 3300

We will acknowledge your referral within two working days.