**Referral and Screening Form (YNFT002)**

Accoras you.nique is a free and voluntary service, where the child or young person is our client and must bewilling to engage with us. The you.nique program works with young people who:

* Are aged between 0-18 years and are currently not in foster or protective care
* Are in the *early stages* (showing signs or symptoms) or at risk of developing a mental health concern
* Have support from a parent, carer or significant adult; and
* Live within our service area

Please confirm:

🞏 The child or young person is aware of this referral and is **willing**, **motivated** and **able** to engage with Accoras you.nique 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.

***All referrals are discussed at our weekly team meetings***

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| **Referral Details** |
| Date of Referral |  |
| Referrer name and position/organisation  |  |
| Contact number and email address |  |

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| **Child or young person details** |
| Full name |  | Preferred name |  |
| Primary address |  | Date of birth |  |
| Gender |  | Contact number (if appropriate) |  |
| Country of birth |  | School attending |  |
| 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 |
| Are you aware of any orders in place? (Child Safety, custody, DVO) | ☐ No☐ Yes – details: |

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| **Parent or carer details** |
| Full name/s |  | Relationship/s to child or young person |  |
| Contact details | Mobile: |
|  | Email: |
| Address:  |
| Do the parents or carers require an interpreter? | ☐ No☐ Yes - language:  |

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| **Reason for referral** |
| Does the child or young person have a confirmed or suspected diagnosis in any of these areas?☐ Mental health concern ☐ Physical health concern ☐ Behavioural concern ☐ Developmental/Learning disorder ☐ Other*Details:* |
| Please provide more information to help us determine the needs of the client or young person: *The child or young person is: (please expand below)*☐ Feeling stressed, anxious or worried ☐ Feeling down, sad or depressed ☐ Difficulties with relationships☐ Lacking self-esteem or confidence ☐ Feeling angry or frustrated ☐ Self harm or suicidal ideations☐ Experiencing social/family difficulties ☐ Experiencing trauma related symptoms ☐ Other (please describe below)*Details:* |
| Current/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? |

**South Brisbane Referrals** **Gold Coast Referrals**

referralsSB@accoras.com.au referralsGC@accoras.com.au

(07) 3255 6555 (07) 5679 3300