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

Accoras You.nique 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 and be willing to participate within the You.nique program;
- Have a parent or significant adult who can be proactive, and work with their 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 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 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.

We will acknowledge your referral within two working days

Referral Details			
Date of referral		Contact number	
Referrer details			
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: _____		

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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	Main language spoken	
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: (please expand below)

☐ Feeling stressed, anxious or worried

☐ Having difficulties with peer relationships

☐ Feeling angry or frustrated

☐ Experiencing social/family difficulties

☐ Having school refusal/attendance concerns

☐ Feeling down, sad or depressed

☐ Lacking self-esteem or confidence

☐ Self harming or having suicidal ideation

☐ Experiencing trauma related symptoms

☐ Other (please describe below)

Please provide further details (explain what is going on for the child/young person that requires support):

Family history (family dynamic; household members):
Current and previous services provided to young person and family:
Strengths of family and young person (what is working well)?
What outcomes would you like to see as a result of us working with the child or young person?

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