 Social Inclusion

**Family and Mental Health Support Service (FMHSS)**

Family Relationship Centre

38 Beach Road, Christies Beach SA 5165

**Ph**: (08) 8202 5200, **Fax**: 8202 5201

**Email**: FMHSSintake@unitingcommunities.org

**PLEASE READ AND COMPLETE AS MUCH INFORMATION AS POSSIBLE – THIS HELPS US WITH YOUR REFERRAL**

***FMHSS Commitment/Criteria***

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| *The FMHSS is a free and confidential early intervention service providing support to young people up to 18 years and their families where there may be challenges existing that are causing risk to the child’s mental health. Some of the indicators of this might be difficulty with emotional regulation, changes to behaviour such as withdrawal/outbursts, anxiety, problems at school and disturbed sleep.*  *We work with the whole family to provide therapeutic support, counselling and case management. Our focus is to improve wellbeing and support children as they develop resilience and confidence. Families and services seeking a referral are reminded that our service* ***does not work solely with parents around parenting skills (although we can recommend superb programmes), or children under Guardianship. Please do contact us if you are unsure and would like some guidance.*** |

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| --- |
| **REFERRAL DATE:** |

**REFERRER DETAILS**

|  |  |
| --- | --- |
| **Name** |  |
| **Organisation/**  **Relationship to child** |  |
| **Address** |  |
| **Phone** |  |
| **Email** |  |

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| --- | --- |
| **HAS CONSENT BEEN PROVIDED BY PARENT/**  **CARER FOR FMHSS TO MAKE CONTACT?** | YES  NO  **(How do they wish to be contacted?):** |

**NAME OF CHILD/CHILDREN BEING REFERRED**

|  |  |  |
| --- | --- | --- |
| **Name/s** | **Child 1** | **Child 2** |
|  |  |
| **DOB** |  |  |
| **Address** |  | |
| **Phone** |  | |
| **School and year** |  |  |
| **Culture/Ethnicity** | **Aboriginal**   **Torres Strait Islander** | **Aboriginal**   **Torres Strait Islander** |
| Other cultural background\_\_\_\_\_\_\_ Was this young person born in Australia? Y  N  If not born in Australia – please add country \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Languages spoken** |  | |

**NAME OF PARENTS/CARERS**

|  |  |  |
| --- | --- | --- |
| **Name/s** | Parent/Carer | Parent/Carer |
|  |  |
| **Relationship to Child/Children** |  |  |
| **Lives with child?** | Yes  No  If no please fill in below | Yes  No  If no please fill in below |
| **DOB** |  |  |
| **Address** |  |  |
| **Phone** |  |  |
| **Email** |  |  |

**REFERRAL INFORMATION**

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| **SCHOOL ATTENDANCE:**  **Enrolled and attending:**  Yes **Is non-attendance a concern:**   Yes  Details: |

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| **REASON FOR REFERRAL –** Consider details of the child’s story and what has prompted you to refer them. What are the impacts of mental health? Has the child experienced trauma in their life and what are the priority presenting issues of this/your family. **How might you hope the FMHSS can support them/you?** |

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| **DETAILS OF MENTAL/PHYSICAL HEALTH DIAGNOSES (ALL FAMILY MEMBERS?):** |

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| **WHAT OTHER SUPPORTS/SERVICES ARE IN PLACE? ARE THERE FAMILY MEMBERS THAT GIVE SUPPORT?:** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **ARE THERE ANY COURT ORDERS IN PLACE FOR THE CHILD?** | | | | |
| YES | NO | | Details | |
| **IS THE CHILD IN THE CARE OF THE STATE?** | | | | |
| YES | | NO | | *Please see above FMHSS Criteria* |
| **DOES THE CHILD/YOUNG PERSON HAVE AN NDSI PLAN or ARE THE FAMILY SEEKING AN NDIS PROVIDER OR APPLYING FOR NDIS?** | | | | |
| YES | | NO | | Details |

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| --- | --- | --- |
| **HAVE SAPOL OR DCP BEEN INVOLVED WITH FAMILY? PLEASE GIVE DETAILS:** | | |
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| **PLEASE PROVIDE ANY SAFETY INFORMATION YOU ARE AWARE OF FOR OUR OUTREACH WORKERS. IS THERE ANYTHING THEY SHOULD BE AWARE OF BEFORE ATTENDING SUCH AS THE PRESENCE OF A DOG ETC?** |

**FMHSS Worker to complete**

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| Enquiry Date: |

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| --- | --- | --- | --- |
| **CONTACT LOG** | | | |
| **Date** | **Time** | **Worker** | **Action Taken/Next steps** |
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| **INITIAL CONTACT SUMMARY** | | | |
|  | | | |
| **Outcome from phone intake:**  Closed / No further action  Sent to Senior Practitioner for allocation | | | |
| **Have preferences been made in relation to male/female workers/LGBTIQ etc?**  **Have preferences been made as to availability/days times preferred?** | | | |