



Arafmi

Mental Health Carers & Friends Association (WA) Inc

**REFERRAL
ARAFMI YOUTH SERVICES WA**

Please note: a separate form is required for each child

Please indicate the specific ways you would like ARAFMI to assist:

- Counselling**

 Education

 Recreational Activities

Full name of child: _____ DOB: / /
(Surname first)

Full name of parent/guardian: _____
(Surname first)

Address: _____
_____ P/C: _____

Day time phone: _____ After hours phone: _____

Email: _____

Name of school attended by child: _____

Person to contact in an emergency: _____

Day time phone: _____ After hours phone: _____

Name of any additional support person (Spouse, parent etc.):

Name of referrer: _____ Phone No: _____

Agency/organisation relationship to child: _____

How is the child related to the person with a mental health issue? _____

Who has the mental health issue in the family? _____

Diagnosis of relative with a mental illness: _____

Details of family (please attach a family tree if possible including ages of siblings):

Ethnic background: _____ Interpreter required? YES/NO

Are both the child and family aware that a referral to Youth Services has been made? YES/NO

Previous and/or existing contact with other agencies/organisations (e.g. Department of Child Protection) - Please list each agency/organisation that the child is currently, or has previously been, linked with (please include the name of the worker and contact details):

Has the child participated in groups before? YES/NO

Are there any reasons this child would not be appropriate for group work? YES/NO

Presenting problems and/or issues for the child. In what specific ways would you like Arafmi Youth Services to assist?

Are you aware of any aggressive behaviour (physical, verbal) and/or self harming behaviour past or present which involves this family or the child referred? YES/NO

If 'Yes', please provide details: _____

Arafmi prides itself in abiding by the National Privacy Principles and Guidelines endorsed by the Office of the Privacy Commissioner. All steps are taken to ensure that the information we hold is protected from unauthorised use or access. Clients are able to access any information that ARAFMI stores about them.

To be completed by parent/guardian of child being referred

RELEASE OF INFORMATION

I (name) _____ hereby authorise (health professional)

_____ of (agency/organisation)

_____ to release information relevant to the completion of this form as well as that required by Arafmi Youth Services WA to assist them in working with my child.

Signed: _____ Date: / /



Permission to Share Information

I, _____ give permission for
(Name of parent/guardian)

Arafmi to contact and exchange information with my child's school:

(Name of school)

For the purposes of counselling to occur at that school with my child/ren

Name: _____

Date of Birth: _____

Name: _____

Date of Birth: _____

Signed: _____ Date _____
(Parent/Guardian Signature)

