easternhealth

EASTERN HEALTH FaPMI PROGRAM
ALL PROGRAMS REFERRAL FORM 2018

Please tick which program/s you are referring the child/ family to:

☐ CHAMPS After School Program ☐ CHAMPS Martial Arts as Therapy program (MAT)
☐ FaPMI Family Fun Day

DATE OF REFERRAL: _____

Child's Information

Child's name: _____ M / F Age D.O.B . / /

Current Address: _____ Postcode: _____

Home Tel. No. _____ Mobile phone No. _____

Living with: _____

Aboriginal/ Torres Strait Islander: Y / N Ethnicity & Country of Origin:._____

Language spoken: English Y/N Other? specify: _____

School:_____ Education level: _____

Child Worker/ school counsellor (if applicable):_____

Child's Diagnosis (if applicable): _____ UR number (if applicable or known) _____

Parent/Carer Information.

1. Name (Primary carer): _____ M / F D.O.B . / /

Diagnosis (If applicable) _____ UR number (if applicable or known) _____

Relationship to Child: _____ Language spoken: English Y/N Other? specify: _____

Address: _____ Postcode: _____

Home Tel. No. _____ Mobile phone No. _____

Email address: _____

2. Name (2nd parent/guardian): _____ M / F D.O.B . / /

Diagnosis (If applicable) _____ UR number (if applicable or known) _____

Relationship to Child: _____ Language spoken: English Y/N Other? specify: _____

Address: _____ Postcode: _____

Home Tel. No. _____ Mobile phone No. _____

Email address: _____

3. Other carers name _____ Relationship to child eg Foster carer/permanent carer _____

Tel. No. _____ Mobile phone No. _____

This referral has been discussed with Parent/s or guardian on Date: / /

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Referrers perception of the severity of impact of mental illness on family functioning:

0 1 2 3 4 5 6 7 8 9 10
No impact severely disruptive

Referrers perception of the child's understanding of mental illness:

0 1 2 3 4 5 6 7 8 9 10
No understanding excellent understanding

Background Information

Reason for referral: _____

_____

_____

Brief history of child/family (e.g. relationship between parents and parent/child, recent episodes, etc.):

_____

_____

_____

Other services/family members currently supporting child and family (e.g. mental health service, counselling, etc.):

Name:_____ Phone No. _____

Nature of support: _____

_____

Name:_____ Phone No. _____

Nature of support: _____

_____

Has the child attended a CHAMPS program before? Yes/No/don't know

If yes, please give details if known: _____

Any other information: _____

_____

_____

Worker information

Name of referring worker: _____ Name of Agency _____

Agency Address: _____ Postcode: _____

Tel. No.'s _____Email address:_____

Please return to: FaPMI Program
C/O Murnong Clinic, 4 Bona St Ringwood East 3135. Ph: 9871 3988 Fax: 9871 3977
Email: fapmi@easternhealth.org.au