

EASTERN HEALTH FaPMI PROGRAM ALL PROGRAMS REFERRAL FORM 2021

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

- CHAMPS After School/Holiday Program (8-12yo) Martial Arts as Therapy program (MAT)
- FaPMI Family Fun Day Space 4 Us / B4U programs (12-18yo)
- Newsletter Secondary Consultation

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: / / and consent has been given to share information between Eastern Health and other organisations involved in the provision of FaPMI groups.

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 Programs Coordinator
C/O Murnong Clinic, 4 Bona St Ringwood East 3135. Ph: 9871 3988 Fax: 9871 3977
Email: fapmi@easternhealth.org.au**