easternhealth

VICTORIA State Government

the bouverie centre

The Victorian FaPMI Program
Families where a Parent has a Mental Illness

EASTERN HEALTH FaPMI PROGRAM REFERRAL FORM 2020

Please tick which FaPMI service you are referring the child/ family to:

☐ Child peer support groups –CHAMPS (8-12yrs) ☐ Martial Arts as Therapy program (8-12yrs)

☐ Teen Peer support groups - Space 4 Us (12-18yrs) ☐ FaPMI Family Fun Day

☐ Brokerage funds/vouchers ☐ Secondary consultation ☐ Newsletter

Child's Information

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

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 family had involvement with FaPMI previously? 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:______________________

Date referral completed / /

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