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| The FaPMI Program provides information and resources to support families where a parent has a mental illness across the Eastern region, including co-ordination of peer group programs. Please indicate reason for referral:

|  |  |
| --- | --- |
|[ ]  CHAMPS ( 8-12yo) |[ ]  Martial Arts as Therapy program (MAT) |
|[ ]  FaPMI Family Fun Day |[ ]  Space 4 Us / B4U programs ( 12-18yo) |
|[ ]  Newsletter  |[ ]  Other: |

Please note – FaPMI does not provide direct family support or case management.Date of Referral:       Email completed referral to: fapmi@easternhealth.org.au  |
| **Child Details:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Given Name:** |       | **Surname:** |       |
| **DOB:** |       | **Gender:** | Male / Female / Non Binary |
| **Address:**  |       | **Child/Young Person Phone Number:** |       |
| **Living with:** |       | **School & Grade level:** |       |
| **Child Diagnosis (if applicable):** |       | **Supports e.g. school counsellor:** |       |
| **Child Medical History / Allergies:** |  | **Other:** |  |
| **Sibling Name/s:** |  | **Gender/DOB:** |  |

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| --- | --- | --- | --- |
| **Aboriginal or Torres Strait Islander** | [ ] Yes | [ ] No |  |
| **CALD? (Cultural Background)** | [ ] Yes | [ ] No | [ ] Interpreter required  |
| **Consent for FaPMI referral?** | [ ] Yes | [ ] No |  |
| **Who is the key contact person for this referral? Parent/Carer/Young Person name?** |

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| **Parent/Carer Details:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Given Name (Primary Carer):** |       | **Surname:** |       |
| **DOB:** |       | **Gender:** | Male / Female / Non Binary |
| **Address:**  |       | **Phone Number:** |       |
| **Email:**  |       | **Relationship to child:** |       |
| **Diagnosis (if applicable):** |       | **URN (if applicable):** |       |

|  |  |  |  |
| --- | --- | --- | --- |
| **Given Name (Parent/Carer):** |       | **Surname:** |       |
| **DOB:** |       | **Gender:** | Male / Female / Non Binary |
| **Address:**  |       | **Phone Number:** |       |
| **Email:**  |       | **Relationship to child:** |       |
| **Diagnosis (if applicable):** |       | **URN (if applicable):** |       |

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| **Purpose of referral to FaPMI:**       |
| **Brief history of child/family (e.g. relationship between parents and parents/child, siblings, significant events, strengths etc.)?**     **Describe impact of mental illness on family wellbeing:**     **Referrers perception of the child’s understanding of mental illness:**     **Legal Issues (e.g. child protection, family violence, IVO’s, family court, forensic):**      |
| This referral has been discussed with Parent/s or Carer on Date: / / and consent has been given to share information between Eastern Health and other organisations involved in the provision of FaPMI groups [ ] Yes |
| **Other services/family members current supporting child and family (e.g. mental health, counselling, others etc.):**

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| --- | --- | --- | --- |
| **Name:** |       | **Phone:** |       |
| **Email:** |       | **Type of Support:** |  |
| **Name:** |       | **Phone:** |       |
| **Email:** |       | **Type of Support:** |  |

 |
| **Referrer Details:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Referrer Name:** |       | **Designation:** |       |
| **Program/Role:** |       | **Date of Referral :** |       |
| **Contact phone/email:**  |       | **Referrer Signature:**  |  |

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| **Outcomes (FaPMI to complete):**

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| --- | --- |
|[ ]  Secondary Consultation – provider:   |[ ]  Unable to contact |
|[ ]  Group programs – specify details/dates: |[ ]  Declined Engagement – reason if known: |
|[ ]  Information/resources provided |[ ]  Referral to other – please specify: |
|[ ]  Other – please specify:   |  |  |

  |
| **FaPMI Co-ordinator Name**: **Signature** (*sign after printing*): **Date**: |