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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](mailto: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:** |  | |
| |  |  |  |  | | --- | --- | --- | --- | | **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?** | | | | |
| **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.):**   |  |  |  |  | | --- | --- | --- | --- | | **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:** |  | |
| **Outcomes (FaPMI to complete):**   |  |  |  |  | | --- | --- | --- | --- | |  | 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**: |