FEH201151

Eastern Health

FaPMI REFERRAL
FAMILIES WHERE PARENTS HAVE A MENTAL ILLNESS

UR Number:

Surname:

Given Name:

Date of Birth: Sex:

AFFIX PATIENT LABEL HERE

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:

☐	More information about FaPMI	☐	FaPMI group programs for children and / or parents
☐	FaPMI Family Fun Day	☐	Child & Young Person support (CYP) worker
☐	Newsletter	☐	Secondary consultation

Please note – CYP workers can provide families with short term psychosocial support and assist with referrals for children & young people. The FaPMI team are unable to provide ongoing family case management.

This referral has been discussed with Parent(s) or Carer on Date: and consent has been given for this referral ☐

Child / young person details: (Please complete as much detail as you can)

Child 1 Full Name		DOB / age		Gender		Child diagnosis (If applicable)	
Child 2 Full Name		DOB / age		Gender		Child diagnosis (If applicable)	
Child 3 Full Name		DOB /age		Gender		Child diagnosis (If applicable)	
Child 4 Full Name		DOB / age		Gender		Child diagnosis (If applicable)	

Family details:

Aboriginal or Torres Strait Islander	☐ No	☐ Yes	
CALD? (Cultural background)	☐ No	☐ Yes	**Describe**
Interpreter required	☐ No	☐ Yes	**Language**
Legal Issues e.g. court orders, FV.	☐ No	☐ Yes	**Describe**

Allanby Press EH201151 22/10/25

Eastern Health

FaPMI REFERRAL
FAMILIES WHERE PARENTS HAVE A MENTAL ILLNESS

UR Number:

Surname:

Given Name:

Date of Birth: Sex:

AFFIX PATIENT LABEL HERE

Parent / carer details:

Parent / carer 1 Given name		Surname:	
DOB:		Gender:	
Address:		Phone Number:	
Email:		Relationship to child:	
Diagnosis (If applicable):		URN (If applicable):	
Parent / carer 2 Given name		Surname:	
DOB:		Gender:	
Address:		Phone Number:	
Email:		Relationship to child:	
Diagnosis (If applicable):		URN (If applicable):	

Who is the Primary carer / guardian? (Give details if different to above)

Please describe child and families experience of mental health and wellbeing: consider relationships, strengths significant events etc

What is the purpose of the referral to FaPMI?

Are there other services / family members providing support to the child or family? (If yes, please list names and contact details if known)

Who is the key contact person for this referral? Parent / carer / young person name?

Referrer details:

Referrer name:		**Agency**	
Program / role:		**Date of referral:**	
Contact phone / email:		**Referrer signature:**	

Email completed referral to: fapmi@easternhealth.org.au

EH 201151 FAPMI REFERRAL - FAMILIES WHERE PARENTS HAVE A MENTAL ILLNESS