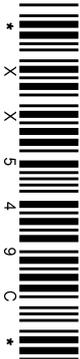


REFERRAL TO INFANT, CHILD AND YOUTH AREA MENTAL HEALTH AND WELLBEING SERVICE

Consumer Last name*		First name/s*	
<i>*mandatory fields</i>			
<p>Alfred Health's Infant, Child and Youth Area Mental Health and Wellbeing Service is a coordinated mental health service for infants, children and young people, as well as their families who live in the following local government areas</p> <p>Port Phillip, Stonnington and Glen Eira (north of North Road): Ages 0 -26 Glen Eira (south of North Road) Bayside and Kingston (west of Boundary Rd) Ages 0–18</p>			
12-26 yr program	Level 2, 999 Nepean Highway, Moorabbin, Victoria 3189		
0-11 yr program	Level 3, 1001 Nepean Highway, Moorabbin, Victoria 3189		
	T: 03 8552 0555	F: 03 8552 0444	E: CYMHSintake@alfred.org.au
Has the consumer / parents / carers agreed to this referral and understand the referral reasons		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Consumer details			
Chosen name			Date of birth*
Sex at birth	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other		Gender identity <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Non binary <input type="checkbox"/> Not stated <input type="checkbox"/> Prefer not to answer
Address			
Telephone		Email	
Interpreter required? <input type="checkbox"/> Yes <input type="checkbox"/> No		Language	
Indigenous status	<input type="checkbox"/> Not Aboriginal or Torres Strait Islander		<input type="checkbox"/> Aboriginal and Torres Strait Islander
	<input type="checkbox"/> Torres Strait Islander not Aboriginal		<input type="checkbox"/> Prefer not to answer
	<input type="checkbox"/> Aboriginal not Torres Strait Islander		<input type="checkbox"/> Not specified
Cultural considerations / support needs			
Family details			
Parent / carer / guardian	Name		Relationship to consumer
	Address		
	Telephone		Email
Parent / carer / guardian	Name		Relationship to consumer
	Address		
	Telephone		Email
Consumer lives with	<input type="checkbox"/> both parents together <input type="checkbox"/> share custody between parents <input type="checkbox"/> mother only <input type="checkbox"/> father only <input type="checkbox"/> other		
Is Child Protection (DFFH) currently / recently involved with this family			<input type="checkbox"/> Yes <input type="checkbox"/> No
Referrer		Date of referral	
Name		Profession	
Organisation & address			
Telephone		Email	
What is your current level of involvement with this consumer			



REFERRAL TO INFANT, CHILD AND YOUTH AREA MENTAL HEALTH AND WELLBEING SERVICE

Consumer Last name*	First name/s*
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Referral details
What are the mental health concerns requiring assessment and / or intervention?
What support are you hoping this service will provide?
Are there any immediate risk issues?
What is the interim management plan to address these risk issues?
Who else is currently involved in this consumer's support network, such as family services / professionals?
Known diagnosis and disabilities including intellectual disability
Prescribed medications <i>(or attach a list)</i>
Additional information <i>(attach relevant correspondence, specialist reports)</i>

Return referral to CYMHSintake@alfred.org.au

Referrals are triaged according to risk. You will be contacted on receipt of referral.
Intake will mostly progress with a telephone call to the family.

Escalation contacts

8552 0555	Monday to Friday, 8:30 am to 5:00 pm
After hours crisis	
1300 363 746	Alfred Health Triage: Port Phillip, Stonnington or Glen Eira (north of North Rd)
1300 369 012	Monash Health Triage: Glen Eira (south of North Rd) Bayside or Kingston