Trauma Treatment Service

REFERRAL FORM

Please tick which service you are filling this form for

☐ **Elver Program** or ☐ **LINKS - Trauma Healing Service**.

PROGRAM ELIGIBILITY – use the Program Eligibility Criteria to select the appropriate service

SERVICE 1: The Elver Program

- Living in residential care/ITC in NSW &/OR has a CAT score of 5 or 6; and
- Receives/requires additional supports to meet complex care needs; or
- Has complex care needs requiring support to transition to another setting eg ITC care provider, foster care, family etc.

SERVICE 2: LINKS - Trauma Healing Service

☐ 16 years and under who are in statutory foster/relative/kinship care where these placements are unstable and children are at high risk of entering residential care.

Placement instability indicators include:

Please tick appropriate boxes

- ☐ where the child has had 2 or more placements in the past 6 Months; or
- ☐ where respite care use has increased in the past 12 months; or
- ☐ where the child is aged under 12 and was previously in a residential care placement (prior to 1 October 2017).

☐ The child and caregiver are aware that the referral has been made and agree to attend the LINKS Trauma Healing Service office for intervention.

Child/Young Person's Details

Name

KiDS Number | ChildStory ID

Date of Birth | Legal Status

Current Address

Date of referral

Age at entry into OOHC

Length of Placement

Cultural Background ☐ Aboriginal/Torres Strait Islander Other

Interpreter needed ☐ No ☐ Yes → If yes - language required

Carer's Name(s)

Home Phone | Mobile

Casework Agency Details

Agency with Case Management

Address

Caseworker name | Ph:

Caseworker manager name | Ph:

Agency Psychologist/ Clinician involved ☐ No ☐ Yes → if Yes - Name | Ph:

Please ensure **Affidavit** and/or **Care Plan** is attached.

Reason for Referral

Has this child/young person previously accessed mental health services?

☐ No ☐ Yes ⟶ If yes, please list all services

Reason for referral/Issues of Concern - (limit to 250 words)

Possible Behaviours - (tick if a current concern)

- ☐ Attention/Concentration
- ☐ Aggression
- ☐ Attachment/relationship issues
- ☐ Disordered Thought
- ☐ Enuresis/Encopresis
- ☐ Sleep Disturbances
- ☐ Challenging Behaviour
- ☐ Substance Abuse
- ☐ Self harm
- ☐ Anxiety
- ☐ Intellectual Disability
- ☐ Issues with food
- ☐ Dissociative Symptoms
- ☐ Emotional Dysregulation
- ☐ Peer problems
- ☐ Parentified
- ☐ Depression
- ☐ Concerns not otherwise noted

Current Placement Details

Type of Placement:

☐ Rel/Kin ☐ Foster care ☐ Residential Care/ITC ☐ Other - please specify:

Current Placement Status:

☐ New (less than 6 months) ☐ Stable ☐ Stable but stressed ☐ Verge of breakdown

Current Placement - Household Members (incl. ages and gender of co-resident for residential care)

Name of Family /Household Member	Relationship to Referred Child	Age	Placement Type

Educational Details

School | Year/Grade

Address | Special Class

Funding Support ☐ No ☐ Yes → If yes, details

Teacher | Phone

Best Contact at School | Phone

Medical Information

Current GP | Phone

Paediatrician/ Psychiatrist | Phone

Diagnosis (current and by whom)

Current Medication

Previous Diagnosis (date and by whom)

Other Services Involved - (current and in the last two years)

Service/Agency	Nature of Involvement	Contact Person and Details

WHS

Are there any risk issues for the team?

☐ No ☐ Yes → If yes, please provide details

Signatures

Caseworker name _____ Signature _____ Date _____

Manager Caseworker name _____ Signature _____ Date _____

PLEASE ATTACH CURRENT CLIENT INFORMATION FORM, BIS PLAN & ANY RELEVANT ASSESSMENT REPORTS FROM THE PAST 2 YEARS

- Completed forms should be emailed to CAU - centralaccessunit@facs.nsw.gov.au
- CAU staff will forward the referral information to the relevant Trauma Treatment Service.
- You will receive a confirmation email when your referral is received by the relevant Service.
- The referral will be discussed at a weekly intake meeting to determine suitability and allocation. A representative from the relevant service will then send an email to you detailing the outcome of the intake meeting and next steps.

Intake and Allocation Outcome

Date referral received at CAU _____ Date referral received at Trauma treatment service _____

Referral Outcome:

☐ Accepted

☐ Not accepted – Recommend follow up with local Manager, Psychological Services or referral to External Provider

☐ Decision pending – awaiting further information

Manager name _____ Signature _____ Date _____