

**Victorian Aboriginal Health Service (VAHS)**

**Family Counselling Service (FCS)**

**238-250 Plenty Road, Preston 3072**

**Ph: (03) 9403 3300. Fax: (03) 9403 3399.**

**www.vahs.org.au**

*The VAHS Family Counselling Service provides culturally safe social emotional wellbeing and mental health counselling, cultural healing and recovery programs, care coordination and outreach support.*

**FCS Referral Form**

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| **Date:**  CHILD/ADOLESCENTADULT | | **Is there a Mental Health Care Plan?**  YES NO  If NO, please organise if the referral is for counselling or psychiatry. |
|  | | **Has the client been referred to Head 2 Help?**  YES NO  If YES, please do not refer to FCS. |
| Referral is: | Urgent (client at risk to self or others) | | |
| Referral Pathway: | Phone Call Fax Email Walk-In | | |

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| **CLIENT INFORMATION** | **REFERRER DETAILS** |
| Surname: | Surname: |
| Given Names: | Given Names: |
| Date of Birth: | Provider Number: |
| Gender: | Agency: |
| Country/Mob (if known): | Postal Address: |
| Address: | Email: |
| Phone/Mobile: |  |
| Other Contact: |  |
| Patient Medicare No: Medicare Reference No: | |

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| **Significant Others (if relevant)** | |
| Name of Mother:  Contact Details: | Name of Father:  Contact Details: |
| Current Carer/s:  Contact Details: | Agencies Involved:  Contact Details: |
| Siblings: | Name of School/Kinder/Day Care: |

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| **Who can we contact if necessary** (carer/friend/family):  Name:  Phone: Relationship to Client: | |
| Has the person agreed to this referral?  YES  NO | Is the referral related to a Court Order or Legal Proceedings?  YES  NO |

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| Is the person an Aboriginal and/or Torres Strait Islander?  YES  NO  If No, please do not refer to VAHS FCS.  *Please note: VAHS Family Counselling Service can only accept referrals for Aboriginal and/or Torres Strait Islander people.* |
| Has this person used the services of VAHS Family Counselling before?  YES  NO |

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| **What is the reason for referral? What are the presenting issue/s?**  **FOR AOD, What has the client requested? E.G. Rehab, Detox, AOD counselling or information about other services. What type of substance(s) is the client currently using and how frequently?**  **Does the client require Care Coordination support to address multiple presenting issues and support with navigating various services?**  **What other services are involved?** |

**SERVICES REQUIRED (\* this section is mandatory to process referral \*)**

**ADULT CHILD/ADOLESCENT**

Psychiatry Parenting

General Counselling General/Consulting/Therapy

AOD Psychiatry

Care Coordination Assessment & Treatment

CASA Language/Learning Developmental Assessment

Financial Counselling Youth Justice



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| **RISK -** Is the client at risk of self-harm or suicide/harm to others/any further details of concern? |
| **Current and previous treatment** (include psychotherapy, past involved services): |
| **Current and previous medication:** |

**Please Note:**

Referrals to VAHS/FCS for a **Social Worker, Occupational Therapist** or **Psychologist** must include (i) Referral Form, (ii) Mental Health Care Plan and (ii) if applicable, an ATAPS referral and consent form for Psychologists registered under the ATAPS scheme.

Only people of Aboriginal and/or Torres Strait Islander descent can access FCS services.

Referrals to a VAHS/FCS **Psychiatrist** must include (i) Referral Form or a GP Referral Letter (ii) List of Current Medications and (iii) a Discharge Summary (if the referral is from a psychiatric admission).

Enquiries about beds in St Vincent's Koorie Unit, contact VAHS/FCS Intake Worker. Ph: 9403 3300.

A risk assessment must be completed for every psychiatric client.

Office Use Only

Received by .............................................. Date Received ...................................... Signature.............................................