|  |  |  |
| --- | --- | --- |
| Please email your referral to [supportingrecovery@lchs.com.au](mailto:supportingrecovery@lchs.com.au) | Date: |  |

A separate Referral Form is required for each person referred.

Please include as much relevant information as possible to minimise repetition of information already gathered.

|  |
| --- |
| Please secondary consult with us BEFORE sending through any children’s referrals (under 16years) |

|  |
| --- |
| Gippsland Supporting Recovery Program aims to provide a range of therapies for children, young people, adults and/or families seeking support to heal from experiences of family, domestic, and/or sexual violence. Our service extends to those from Latrobe City or Baw Baw Shires and feel emotionally ready for the healing process.  We are not an emergency service and are not able to respond to immediate crisis needs.  If deemed ineligible, we will discuss available options. |

Consent

Note: If referral is a child or young person, consent must be obtained from parent/legal guardian, unless a mature minor.

|  |  |  |  |
| --- | --- | --- | --- |
|  | The referred person agrees to this referral |  | The referred person is a mature minor |
|  | The referred person is part of a family group requiring support | | |

# Eligibility

|  |  |
| --- | --- |
| **Has past family, domestic and/or sexual violence been identified?** | Yes  No |

Describe:

|  |
| --- |
|  |

|  |  |
| --- | --- |
| **Is family, domestic and/or sexual violence currently occurring or *within the last 3 months*?** | Yes  No |

Describe:

|  |
| --- |
|  |

|  |  |
| --- | --- |
| **Are there current mental health conditions or needs?** | Yes  No  Unknown |

Describe mental health history and current mental health conditions, symptoms & medications:

|  |
| --- |
|  |

|  |  |
| --- | --- |
| **Medication compliance:** | Yes  No  Unknown |

|  |  |
| --- | --- |
| **Are there other areas of support required?  (e.g housing instability, financial or other crisis needs)** | Yes  No  Unknown |

Describe:

|  |
| --- |
|  |

# Referrer

|  |  |
| --- | --- |
| Is this a self-referral? | Yes (please move to next section)  No (please complete this section) |

|  |  |
| --- | --- |
| Referrer’s name: |  |

|  |  |
| --- | --- |
| Position and organisation: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Email address: |  | Phone: |  |

# Supporting Information

Describe your service support history and your ongoing support to referred person?

|  |
| --- |
|  |

What other service supports are in place?

|  |
| --- |
|  |

Attached documents

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | MARAM Risk Assessment | |  | Safety Plan |  | IVO |  | Mental Health Reports |
|  | Other: |  | | | | | | |

Details (if no information, explain why):

|  |
| --- |
|  |

Who is the person seeking a service?

|  |  |  |  |
| --- | --- | --- | --- |
| First name: |  | Surname: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Preferred name |  | Date of Birth: |  |

|  |  |
| --- | --- |
| Current residential address: |  |

|  |  |
| --- | --- |
| Household occupants: |  |

Describe supporting adult/s (for a child referral):

|  |
| --- |
|  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Preferred ways to contact | | | | | | |  |
|  | Phone No.: |  | Text: | Yes  No | | Text before call: | Yes  No |  |
|  |  |  |  |  | |  |  |  |
|  | Email: |  | | Other: |  | | |  |
|  |  |  | |  |  | | |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Gender: |  | Pronouns: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Country of birth: |  | Cultural background: |  |

|  |  |
| --- | --- |
| Interpreter required: | Yes  No |

|  |  |
| --- | --- |
| Identify as Aboriginal or Torres Strait Islander? | Yes  No |

|  |  |
| --- | --- |
| Would you like to engage with First Nations Engagement Practitioner? | Yes  No |

Children (names, ages, location):

|  |
| --- |
|  |

Emergency Contact if we are not able to reach referred person?

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Contact number: |  |

|  |  |
| --- | --- |
| Relationship to referred person: |  |

# Presenting Needs

Reason for referral?

|  |
| --- |
|  |

What are the areas of concern?

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Anxiety | |  | Feeling depressed |  | Feeling isolated/alone |  | Feelings of shame/worthlessness |
|  | Grief/Loss | |  | Mood swings |  | Parenting challenges |  | Effects of past family violence |
|  | Sexual trauma | |  | Stress |  | Post-Traumatic Stress Disorder symptoms |  | Self Harm/thoughts of suicide |
|  | Other |  | | | | | | |

Additional details:

|  |
| --- |
|  |

Describe supports required to promote recovery:

|  |
| --- |
|  |

Please provide any current mental health diagnoses or conditions:

|  |
| --- |
|  |

What social and community supports are currently in place?

|  |
| --- |
|  |

Thank you for this referral. For further information on the progress of referral,   
email [supportingrecovery@lchs.com.au](mailto:supportingrecovery@lchs.com.au)