

Cusp is a child centred, family focused and strengths-based program that aims to improve vulnerable children and young people's mental health outcomes. Children or Young Person's involvement is voluntary.

A completed referral form, including signed parent/guardian consent is required. Referrers, please complete this form with the family and email the completed and signed referral to mentalhealth@uplyft.org.au For enquiries phone (08) 9245 2441

Eligibility – Child/Young Person who ..

- Is aged 5 - 18 years who are vulnerable to/or are experiencing, the early stages of a mental health issue
- Has Parent/Guardian support for involvement in the program
- Resides in the City of Wanneroo, City of Armadale or City of Gosnells
- Is NOT under a Care and Protection Order from CPFS

In accordance with the Commonwealth Privacy Act (1988) the personal information collected about families will be used in a confidential manner by Uplyft staff strictly for the purpose of facilitating the Cusp program. Clients are able to access their own information

CHILD/REN AND/OR YOUNG PERSON/S BEING REFERRED

	Child 1	Child 2	Child 3	Child 4
Surname				
First Name				
DOB				
Identified Gender				
Aboriginal	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Torres Strait Islander	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
CALD	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Country of birth				
Language spoken at home				
Current living situation				
Disability (if yes, please elaborate)	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Current School				

REFERRAL DETAILS

Put number 1 against the Primary Reason for Referral – Put number 2 against the Secondary Reason for Referral

Physical Health		Personal and family safety		Managing Money		Material Wellbeing		Personal and family safety	
Mental health, wellbeing and self-care		Family Functioning		Age-appropriate development		Community participation and networks		Housing	

REFERRER

Name		Telephone/Mobile	
Agency/School		Email Address	
Has the family consented to this information being shared?			Yes ☐ No ☐
Is the child/ young person aware and consented to this referral?			Yes ☐ No ☐

REFERRAL SOURCE AGENCY

Health Agency		Community Services		Education Agency		Another agency (please name)	
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REFERRAL SOURCE NON-AGENCY

Self		Family		General Medical Practitioner		Another agency (please name)	
Family Functioning		Mental health, wellbeing and self-care		Age-appropriate development		Other party (please name)	

FAMILY AND OTHERS

Parents/Caregivers #1		Parents/Caregivers #2	
Parent/Caregiver		Parent/Caregiver	
DOB		DOB	
Gender		Gender	
Address		Address	

FAMILY AND OTHERS .. Continued

Telephone/Mobile Phone		Telephone/Mobile Phone	
Email		Email	
Aboriginal	Yes ☐ No ☐	Aboriginal	Yes ☐ No ☐
Torres Strait Islander	Yes ☐ No ☐	Torres Strait Islander	Yes ☐ No ☐
Country of birth		Country of birth	
Ethnicity		Ethnicity	
Arrival date in Australia (if applicable)		Arrival date in Australia (if applicable)	
Migration Visa Category (if applicable)		Migration Visa Category (if applicable)	
Humanitarian ☐ Skilled ☐ Family ☐ Other ☐		Humanitarian ☐ Skilled ☐ Family ☐ Other ☐	
Language spoken at home		Language spoken at home	
Interpreter required	Yes ☐ No ☐	Interpreter required	Yes ☐ No ☐

OTHER SIGNIFICANT OTHERS

Relationship to child/young person		Relationship to child/young person	
DOB		DOB	
Telephone		Telephone	
Address		Address	

REFERRAL DETAILS

What are the reasons for referral and what do you hope your child/young person will achieve from the Cusp program? *Please elaborate below:*

Is your child/ young person currently engaging in, or have they recently engaged with a support service/program or counselling? If yes please elaborate below:

What are your child's/young persons' strengths? What are your family strengths? Please elaborate below:

Are there any safety or health issues the Cusp Worker should be aware of? If yes please elaborate below:

Is your family currently involved with Child Protection and Family Support? Are there any known court orders relating to your family? If yes please elaborate below:

CONSENT TO RELEASE INFORMATION

Please note that the following consent needs to be signed by the parent/guardian. Referrals without signed consent will not be accepted.

This referral for _____ (child/young person's name/s) to the Uplyft Cusp program has been made with my consent.

I understand and give consent for Uplyft to collect and store the information provided on its safe digital client management system. This includes the understanding that Uplyft may disclose de-identified information to the Australian Government Department of Social Services (DSS) for the administration of its Mental Health support services.

Uplyft will contact me after the referral has been received to arrange an initial meeting. If this referral has been made by an agency/organisation, I also give consent for Uplyft to contact them to assist further in the intake/allocation process.

Name of referring agency/school (if applicable) _____

Name (parent/guardian) _____

Signature (parent/guardian) _____

Date _____