MH - Cusp Referral Form

FOR-0201

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				

Uplyft.
strong young futures

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 Funcitoning		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)	

REFERRAL SOURCE
NON-AGENCY

Self	○	Family	○	General Medical Practitioner	○	Another agency (please name)	
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

Telehone/Mobile Phone		**Telehone/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 INFOMATION

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 _____