Referral for psychological therapy services

Prior to submitting a referral for psychological services, it is recommended that you consult with the Psychologist allocated to your Hub/Office, or the relevant Supervisor, Clinical Psychologist.

* **Denotes mandatory field**

Referral authorisation

*Location: Select one Other: *Team:	*Case Manager Name: *Case Manager Phone:
*Supervisor's Name:	*Supervisor's Signature:
The supervisor's signature indicates that (if necessary) all relevant parties have given their written consent to be involved in the therapy process and for the therapist to obtain information from other agencies (such as CPS, CAMHS etc.).	
Date of Referral:	

Client

Child details: Please list **all** children to be referred		
*Name (including AKA):	*Culture: Select one	
*Date of Birth:	Gender: Select one	
*Existing Order / Agreement: Select one	Other:	
Date existing order / agreement was obtained:		
Is reunification being actively considered? Yes ☐ No ☐		
Comments:		
Is there a concurrent referral for therapy in place for a sibling/s of the above named child? Yes ☐ No ☐		
Name of sibling/s:		

Families SA consultation

*Has the case been discussed with a Principal Social Worker (PSW)? Yes ☐ No ☐	
*Name of PSW:	*C3MS Record Date:
*Has the case been discussed with a Principal Aboriginal Consultant (PAC)? Yes ☐ No ☐	
*Name of PAC:	*C3MS Record Date:
*Has the case been discussed with a Psychologist? Yes ☐ No ☐	
*Name of Psychologist:	*C3MS Record Date:

Birth family of child

Mother's details	
*Name:	Date of Birth:
Address:	Contact Number:
Mother's current partner's details (if applicable)	
*Name:	Date of Birth:
Address:	Contact Number:
Father's details	
*Name:	Date of Birth:
Address:	Contact Number:
Father's current partner's details (if applicable)	
*Name:	Date of Birth:
Address:	Contact Number:
Biological siblings details	
*a) Name:	Date of Birth:
Who does this sibling live with?	
*b) Name:	Date of Birth:
Who does this sibling live with?	
*c) Name:	Date of Birth:
Who does this sibling live with?	
Other family members/significant others (who may be relevant for the therapist)	
a) Name:	Relationship to Child:
Address:	Contact Number:
b) Name:	Relationship to Child:
Address:	Contact Number:

Foster family / relative or specific child only carer

Carers	
*Names:	Contact Number:
Address:	
*If the carers are relatives, what is their relationship to the child?	
Date Placement Commenced:	
Foster siblings	
*a) Name:	Age:
*b) Name:	Age:
*c) Name:	Age:

Emergency/residential care (e.g. CRC, TA, NGO or Commercial Care)

NB: It is vital that the child be transported to therapy by the Case Manager or an Emergency/Residential Care worker. Therapy can often be unsettling for children and young people, no matter their age, and as such it is important that they have an opportunity to be with a familiar, caring and empathic adult immediately after therapy. As a result, **transportation to or from therapy via taxi is not appropriate**. It is important that one or two consistent people are identified as key placement contacts and become responsible for transportation and liaison with the therapist. This person(s) will become the contact point for the therapist in order to discuss relevant issues or seek information. Please ensure this is considered **prior** to making the referral.

Contact details	
*Key contact names:	Contact Number:
* Carer agency (e.g. Families SA, Hendercare, AFSS):	
* Accommodation name and address:	
Date placement commenced:	
How many other children reside in the placement?	
Names of significant other children in the placement (e.g. siblings, friends)	
*a) Name:	Age:
*b) Name:	Age:
*c) Name:	Age:

School / kindergarten / other learning centre

*Name of school/kindergarten:	* Contact Person:
*Contact Number:	

Other agencies / professionals involved

a) Name of agency: Contact number:	Contact person:
b) Name of agency: Contact number:	Contact person:
c) Name of agency: Contact number:	Contact person:

Other relevant information

Has the child previously received therapeutic input (e.g. from a psychologist, CAMHS, CPS)? Yes ☐ No ☐ If yes, please provide the name of the provider: Nature of Service: Date of Service:
Does the child, or other people being referred, have a history of behaving violently or aggressively towards workers? Yes ☐ No ☐ If yes, please detail:
What other issues must the treating psychologist be aware of?

Relevant documents

Please list the titles of relevant documents (e.g. previous psychological, CPS, educational, relevant medical, criminal history and professional reports) and the date that they were uploaded to C3MS. The referral cannot be actioned until these documents are identified.

*Current Case Plan	*Date uploaded to C3MS:
*Application for a Care and Protection Order	*Date uploaded to C3MS:
	*Date uploaded to C3MS:
	*Date uploaded to C3MS:
	*Date uploaded to C3MS:
	*Date uploaded to C3MS:

Other relevant information (cont.)

*Please briefly describe Families SA's involvement with the family, the child's current situation and relevant history. (Attach a genogram, if available):
* Reason for requesting therapy / Areas requiring therapeutic input: (Please consult the Psychological Therapy Referral Guidelines to inform your referral)

NB: Case managers are responsible for ensuring that the child/young person gets to and is collected from therapy appointments.

Once complete please:

a) Create a referral on C3MS for **Therapy** with Psychological Services (still known as PATI on C3MS) and
b) Attach this referral document