PROGRAM ELIGIBILITY CRITERIA *\* MANDATORY FIELD*

***RYMH is a voluntary service. This form must be completed with the Young Person. To be eligible for this program the Young Person needs to be able to tick all these boxes ☺***

You are aged between 12-25 years

You live within the service area (Parkes, Forbes, Condobolin, Cowra, Coonabarabran, Coonamble, Walgett, Gilgandra, Cobar, Nyngan, Narromine)

You want to improve your wellbeing and mental health

You give consent for the referral ***OR***  You are a parent/guardian and give consent if the Young Person is under 15 years\*

1. INFORMATION ABOUT YOU \*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Name:** |  | **Address:** |  | | | |
| **Phone:** |  | **Email:** |  | **Gender:** |  | |
| **Date of Birth:** |  | **Country of Birth:** |  | **Are you an Aboriginal or Torres Strait Islander person?** | |  |
| **Main language spoken at home** |  | **Do you need help with hearing, reading and writing?** | |  | | |

***Caregiver information is required for young people who give consent for their parent or guardian to be contacted or for young people under 15 years\****

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Primary Caregiver’s Name:** |  | **Address:** |  | | |
| **Phone:** |  | **Email:** |  | **Relationship to Young Person:** | Choose an item |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Emergency Contact\*  *(Required if different from above)*: |  | Address: |  | | |
| Phone: |  | Email: |  | Relationship to Young Person: | Choose an item |

\*If under 15 years and able to meet Gillick competency, parental consent is not required

1. REFERRAL INFORMATION \*

|  |  |  |  |
| --- | --- | --- | --- |
| **REASON FOR REFERRAL (***what are the challenges you are experiencing and what would you like help with)* **\*** | | | |
|  | | | |
| **Are you concerned about your safety?** *eg. Are you experiencing suicidal thoughts or concerned about being harmed?* | Select | **If yes please provide details:** |  |

1. ADDITIONAL INFORMATION

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Can you tell us a bit about your history? (health, family history, living arrangements, what you enjoy doing, what has changed? Etc.)** | | | | | | | |
|  | | | | | | | |
| **Ae you worried about any of the following?** | Not Applicable |  | Deliberate self-harm |  | Substance use/misuse |  |  |
| Unknown |  | Risk of absconding |  | Other (please specify) |  |
| Child Protection |  | Suicidal ideation |  | **Space to write comments:** | |
| Domestic Violence |  | Threat of harm to others |  |
| **What is going well at the moment?** | Close friend/ carer/mentor |  | School |  | Sport |  |  |
| Family |  | Study |  | Other (please specify) |  |
| Boyfriend/Girlfriend |  | Home |  | **Space to write comments:** | |
| Music |  | Creative |  |

|  |
| --- |
| **Who are the important people and supports in your life?** |
|  |
| **Is there anything else you’d like us to know?** |
|  |

1. ADDITIONAL INFORMATION FOR REFFERAL FROM SERVICE PROVIDER \*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name of referrer:** |  | **Relationship to Young Person:** | | Choose an item |  |
| **Phone:** |  | **Email:** |  | | |

1. ADDITIONAL INFORMATION PROVIDED BY SERVICE PROVIDER

|  |
| --- |
| **Suicide/Self Harm Risk Assessment** *(Past suicide attempt(s)? If yes, when? Past Self Harm behaviours? If yes, what? Is there current suicidal intent? Is there a Safety Plan in place? If yes, please attach a copy. Are there other risk factors that increase the risk e.g. substances, homelessness, history of abuse?* |
|  |
| **Current or previous court orders** *(e.g.: Children’s Court, Apprehended Violence Orders, Probation and Parole, Juvenile Justice, Family Court. Risk of Harm from Others - Please advise from whom and any current strategies or legal requirements to keep the young person safe)* |
|  |
| **Are there known worker safety issues? Eg. Violence towards staff** *(What are they, how have they been managed by the referrer?)* |
|  |
| **Other additional information** *(e.g.: informed consent, any previous safety and risk assessments, literacy and numeracy, cultural considerations, Ability to speak English)?* |
|  |

**INTERNAL USE ONLY**

1. REFERRAL OUTCOME\*

| **Date:** |  | Eligible for Service | Ineligible for Service | | |
| --- | --- | --- | --- | --- | --- |
| Accepted | | Waitlisted | Declined | **Reason:** |  |

| **Stepped care service type:** |  | **Allocated to:** |  |
| --- | --- | --- | --- |
| **Date referrer informed of outcome:** |  |  | |
| **Referral and follow up actions:** |  | | |

| **Name:** |  |
| --- | --- |