**Evolve Therapeutic Service Referral Form**

**Instructional note:** This form is to be completed by Child Safety (Department of Children, Youth Justice and Multicultural Affairs - **DCYJMA**). The child safety officer, senior team leader or senior practitioner are required to complete this form.

All information in this form is strictly confidential

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| Date of referral |       | Dates of previous referrals |       |

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| Child/young person details |
| Full Name:(as on Medicare card) |       | Date of Birth: |       | Gender: | Male / Female / X / Non-Binary/ Prefer not to say / Other       |
| First Nations status**:** | Aboriginal | [ ]  | Torres Strait Islander | [ ]  |
| Both Aboriginal and Torres Strait Islander | [ ]   | Neither Aboriginal nor Torres Strait Islander | [ ]  |
| Australian South Sea Islander  | [ ]  | Not stated / unknown | [ ]  |
| Other – please specify:  |
| Medicare Card Number: |  | Card ID: |  | Expiry: |  |

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| Access criteria (please tick) Please note: all 3 criteria need to be met before proceeding with referral |
| Age (under 18) | [ ]  | The referral for assistance relates to severe and complex psychological and or behavioural problems. | [ ]  | Child or young person is subject to an interim or finalised child protection order granting custody or guardianship to the chief executive of the Department of Children, Youth Justice and Multicultural Affairs (DCYJMA); or on an Intervention with Parental Agreement and subject to a child protection care agreement.  | [ ]  |
| Statutory child protection interventions |
| Current order (specify): |       | Date order commenced: |       |
| Date order ends: |       |

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| Referred by | Name | Child safety service centre | Email address | Signature | Date |
| Child Safety Officer |       |       |       |       |       |
| Senior Team Leader or Senior Practitioner |       |       |       |       |       |
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| Legal guardian consent (to refer to Evolve Therapeutic Service and to share information) |
| Name |       | Signature |  | Date |       |
| Young person 14 years and over may give consent to refer to Evolve Therapeutic Service (taking into consideration Gillick Competency) |
| Young person name |       | Signature |  | Date |       |
| Witness name |       | Relationship to young person |       | Signature |  | Date |       |

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| Views and wishes of the child or young person in relation to the referral to the Evolve Therapeutic Service |
| Has the referral been discussed with the child/young person? Yes: [ ]  No: [ ]  If not, why not? |
| Is the child willing to engage with Evolve therapeutic services? Yes: [ ]  No: [ ]   |
| If yes, what are the views, wishes or goals of the child or young person in relation to the referral to Evolve Therapeutic Service?      |

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| Current living arrangements (i.e. with carers (foster or kinship care), biological parent/s, residential service, funded package, in receipt of CRC-PAS funds or alternative care grants, independent living, youth shelter, homeless): |
| Placement type |       |
| Parent/carer/care provider name |       |
| Address |       |
| Telephone number/s |       |
| Primary email Address |       |
| Others in the placement |       |

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| Current education arrangements |
| School/Training facility |       | Contact details |       | Year level |  |
| Key information about the child/young person’s educational/vocational engagement, including current (or risk of) school suspension and/or exclusion:      |

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| Other relevant service providers (e.g., GP, private therapist/psychologist, paediatrician) |
| Service | Role / service provided | Aware of referral? | Supportive of referral? |
|       |       | Yes: [ ]  No: [ ]  | Yes: [ ]  No: [ ]  |
|       |       | Yes: [ ]  No: [ ]  | Yes: [ ]  No: [ ]  |
|       |       | Yes: [ ]  No: [ ]  | Yes: [ ]  No: [ ]  |
|       |       | Yes: [ ]  No: [ ]  | Yes: [ ]  No: [ ]  |

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| Cultural Practice Advisor Involvement: |
| Does the child/young person have a Cultural Practice Advisor involved? Yes: [ ]  No: [ ]  N/A [ ] If yes, provide details:       |
| If no, who is the identified cultural support person and their contact details?       |

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| Reason for referral: Description of primary psychological and mental health problems prompting this referral (e.g.: trauma symptoms, sleep difficulties, relationship and attachment problems, attachment disorders, anxiety, low mood or depression, self-harm, suicidal ideation, aggression, problematic substance use, educational difficulties and communication difficulties). |
| Current presenting mental health concerns?     What do you hope will be achieved for the child from an Evolve Therapeutic Service referral?       |

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| Disability information: |
| National Disability Insurance Scheme (NDIS) participant? | Yes: [ ]   | No: [ ]  | Not Known: [ ]  | NDIS ID: |  |
| Does the child have any diagnosed disabilities? Yes: [ ]  No: [ ]   |
| If yes, what type of disabilities? (i.e.: physical, intellectual, cognitive, sensory, neurological, psychosocial)       |
| Does the child have a suspected disability, yet to be diagnosed? Yes: [ ]  No: [ ]  If yes, what type of disabilities do you think? |

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| Attach the following documents to support referral and decision making and for commencement of initial assessment:  [ ]  Current assessment and outcome form, detailing why the child is subject to ongoing intervention [ ]  Child protection history including the child’s trauma history, suspected child sexual abuse and/or harmful sexual behaviour, history of  domestic and family violence, misuse of alcohol and other drugs, mental health concerns and intergenerational trauma [ ]  Child strengths and needs assessment (most recent) [ ]  Parent strengths and needs assessment (most recent) [ ]  Case plan and cultural support plan (for Aboriginal and/or Torres Strait Islander children and young people) (most recent) [ ]  Family group meeting minutes (most recent) [ ]  Psychosocial and other allied health assessments and reports (all)  [ ]  Education support plan [ ]  Genogram [ ]  Care arrangement referral/PSU referral  [ ]  NDIS plan (if relevant) [ ]  Child protection history summary  [ ]  Placement history summary |

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| INFORMATION SHARING AND PRIVACY CONSENT |
| Information sharing between Evolve Therapeutic Services (Queensland Health) and DCYJMA is pursuant to its role under the *Child Protection Act 1999* amendments (section 159m, section 159n, section 159h). Information sharing is further supported by the MOU between Queensland Health and DCYJMA for Evolve Therapeutic Services. All information provided is to be used for the purpose of mental health assessment and intervention. Evolve Therapeutic Services (Queensland Health) must comply with the National Privacy Principles in the Information Privacy Act 2009. Evolve Therapeutic Services is collecting the child’s/young person’s personal information for the purposes of consumer registration and the provision of the services provided by Evolve Therapeutic Services. The personal information will not be used or disclosed except in certain circumstances such as when required or authorised by law, in connection with your child’s/young person’s ongoing treatment or with consent. For more information visit: <https://www.health.qld.gov.au/consent>. |

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| **Evolve Therapeutic Service location** | **Evolve Therapeutic Services referral email address** |
| Brisbane North | CHQ-CYMHS-EvolveNorth@health.qld.gov.au |
| Brisbane South | CHQ-CYMHS-EvolveSouth@health.qld.gov.au |
| Cairns | evolveintake@health.qld.gov.au  |
| Gold Coast | GCEvolveTS@health.qld.gov.au |
| Ipswich | WM\_MHSS\_EvolveAdmin@health.qld.gov.au |
| Logan | MSAMHS\_Evolve\_Logan@health.qld.gov.au |
| Mt Isa | No generic email |
| Rockhampton | CQMHSEVOLVE@health.qld.gov.au |
| Sunshine Coast | SC-MHAS-DaltonDriveHUB-Admin@health.qld.gov.au |
| Toowoomba  | EvolveIntakeToowoomba@health.qld.gov.au |
| Townsville | Tsv-MH-Evolve@health.qld.gov.au |