Samaritans

Referral to Rural Young Minds

P: 1800 270 738 F: (02) 4931 1060 E: rym@samaritans.org.au

Please Note: This referral is not accepted until an Intake Worker has made contact with the referrer via phone, fax or email. If contact is not made by a worker within 3 working days please call us on **1800 270 738.**

Rural Young Minds (RYM) is not a crisis service. If there are immediate mental health concerns for the young person please dial 000 or go to the closest hospital Emergency Department**.** For urgent concerns call the Mental Health Line on 1800 011 511.

Staff ONLY - Type of Referral: ☐ In person ☐ Fax ☐ Email ☐ Phone		
Referral received on: _____/_____/_____	At time: _____	By: _____ (initial)
Confirmation fax sent _____/_____/_____	At time: _____	By: _____ (initial)

Section A. Details of Young Person

Has the young person agreed to this referral? ☐ Yes ☐ No (please note: referrals will not be accepted without the consent of the young person)	
If the young person is under 16 years, are the parents/carers aware of referral? ☐ Yes ☐ No	
Surname:	First name:
Gender: ☐ Male ☐ Female ☐ Other _____	Date of Birth: _____/_____/_____ Age: _____
Address:	
Suburb:	Postcode:
Phone (home):	Phone (mobile):
Email:	
Which contact/s would the young person prefer us to use? ☐ Home ☐ Mobile ☐ Email	

Emergency Contact:	
Name	Relationship to young person:
Address:	Suburb:
Postcode:	Phone: Mob:

Reason for Referral (Please tick all that apply)

☐ Mental Health ☐ Drug and Alcohol ☐ Recent Suicide Attempt ☐ Accommodation Support

☐ Engagement in Education or Employment ☐ Centrelink Assistance

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Please describe any legal issues that may be present: **Main issue/s:**

Section B. Details of Referrer

☐ Self ☐ Family ☐ Friend ☐ Organisation/Service

Name of Referrer:	Organisation:
Address:	Fax:
Phone: Mob:	Email:

Does the young person see any other services at the moment? ☐ Yes ☐ No

☐ Drug & Alcohol ☐ School Counsellor ☐ Other Counsellor ☐ Juvenile Justice

☐ Community Services ☐ Adult Mental Health ☐ CAMHS (Child and Adolescent Mental Health)

Other (please specify): _____

Please list services accessed in the last twelve months: _____

_____ _____

_____ _____

_____ _____

Does the young person have a regular GP? ☐ Yes ☐ No	Name of GP: Contact number of GP:
Practice name:	
Practice address:	
Does the young person have a mental health care plan? ☐ Yes ☐ No (if yes please attach if possible)	

Other Information (IF KNOWN)

Aboriginal or Torres Strait Islander? ☐ No ☐ Aboriginal ☐ Torres Strait Islander(TSI) ☐ Both

Medicare # (if known):	Reference #:	Exp date:
Healthcare Card # (if known)	Exp date:	
Private Health Insurance: ☐ **Yes** ☐ **No**	Fund: _____	

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