

Barwon Health

Mental Health Therapy Services

Youth Program - Colac



The interim youth MH therapy program is a service for people aged 12-25 who identify as having MH concerns. It provides short-term focussed psychological intervention and single session work. We can only see people who have consented to a referral to Barwon Health's Mental Health Services. The person will be registered with MH services and their therapy documented in Barwon Health's' medical record.

If the person is at high or acute risk of suicide please contact emergency services on 000.

If they have a mental illness in the moderate – severe range that would benefit from psychiatric review and/or case management in conjunction with therapy they can be referred via Jigsaw. Contact Child and Youth triage 1300 094 187.

| Referrer | | | | | | | |
|--|--------------------------|-------------------------------|--------------------------------------|-----------------------------|--------------------------|-------------------------------|--------------------------|
| Name | | | | | Date of Referral | Click or tap to enter a date. | |
| Contact Details | | | | | | | |
| GP/ School Wellbeing Co-ordinator | | | | | | | |
| Young Person | | | | | | | |
| First Name | | | | Middle Name | | | Surname |
| Date of Birth | | Click or tap to enter a date. | | Contact Number | | | |
| Address | | | | | | | |
| Suburb | | | | | | Post Code | |
| Email Address | | | | | | | |
| Country of Birth | | | | | Preferred Language | | |
| Medicare Number | | | | | | | |
| Interpreter Required | | Choose an item. | Aboriginal or Torres Strait Islander | | Choose an item. | | |
| Gender (please circle) | | Choose an item. | | | | | |
| Parent/Guardian/Emergency Contact | | | | | | | |
| Note if the person is under 16, we require a parent/guardian to be documented on this form and to attend the first appointment. | | | | | | | |
| First Name | | | | | Surname | | |
| Relationship to Young Person | | | | | Contact Number | | |
| Do we have the Young Person's permission to speak to the person identified? | | | | | | Choose an item. | |
| Reason for Referral (Please tick) | | | | | | | |
| Anxiety | <input type="checkbox"/> | Depression | <input type="checkbox"/> | Adjustment | <input type="checkbox"/> | Interpersonal difficulties | <input type="checkbox"/> |
| Substance Use | <input type="checkbox"/> | Self-harm | <input type="checkbox"/> | Body image/ Eating disorder | <input type="checkbox"/> | Trauma | <input type="checkbox"/> |

| | | | | | | |
|--|-----------|--------------------------|------------|--------------------------|--------------|--------------------------|
| Service Medium Requested (Please tick) | Telephone | <input type="checkbox"/> | Telehealth | <input type="checkbox"/> | Face to Face | <input type="checkbox"/> |
|--|-----------|--------------------------|------------|--------------------------|--------------|--------------------------|

Main Concerns (include Previous diagnosis)

Impact of problem on functioning

Young Person's hopes for change

Previous and/or current engagement with services

Risk Factors (Please tick)

| | | | | | | | |
|---------------------------|--------------------------|----------------|--------------------------|------------------|--------------------------|--------------------------------------|--------------------------|
| Suicide | <input type="checkbox"/> | Non Accidental | <input type="checkbox"/> | Substance Use | <input type="checkbox"/> | Homelessness | <input type="checkbox"/> |
| Self-Injury | <input type="checkbox"/> | Harm to Others | <input type="checkbox"/> | Anger Management | <input type="checkbox"/> | Family Violence (Victim/Perpetrator) | <input type="checkbox"/> |
| Extreme social withdrawal | <input type="checkbox"/> | Substance Use | <input type="checkbox"/> | Impulsivity | <input type="checkbox"/> | Other | <input type="checkbox"/> |

Comments