PROVISIONAL REFERRAL
FOR CHILDREN (0-12 YEARS)
Psychological Support Services (PSS)

This form is required to refer children (12 years old and under) with, or who are at risk of developing a mild to moderate, mental, emotional or behavioural disorder and for whom for whom available services (including Medicare subsidised services) are not suitable, for assessment and short term psychological intervention.

THIS IS NOT A CRISIS SERVICE, if crisis assistance is required, please call the Mental Health Access Line on 1800 011 511.

Eligible Provisional Referrers Include: School Counsellors, School Principal/Deputy, Directors of Early Childhood Services and Managers in NGO's.

Please Note: This referral is for three (3) FREE provisional sessions only; a combined GP Child Treatment Plan is required to approve further sessions.

Please FAX Completed referrals to CESPHN Intake on: (02) 9330 9988

DATE OF REFERRAL	/ /

Program Eligibility ***(please check each item - patient must meet each criteria below to be referred)***

- ☐ Child lives or goes to school in Central or Eastern Sydney region
- ☐ Child has NOT accessed Medicare rebated psychological services this calendar year under Better Access
- ☐ Child unable to access other available services, including Better Access
- ☐ Child is not currently experiencing domestic violence (if so, a mandatory report must be made) and is not involved in any family law or child protection matters
- ☐ Child is experiencing, or at risk of developing mild to moderate childhood emotional or behavioral concerns.
- ☐ Child would benefit from short term psychological intervention
- ☐ Child is aged 0 – 12 years old and under

REFERRER DETAILS

Name		Position	
Organisation Name		Postcode	
Phone		Fax	
E-mail			

**** please note that if an e-mail address is not provided you will not receive referral confirmation.*

CHILD DETAILS

First Name		Last Name	
Date of Birth		Gender	☐ Male ☐ Female ☐ Other
Address			
Suburb		Postcode	
Healthcare Card	☐ Yes ☐ No	NDIS Participation	☐ Yes ☐ No
Aboriginal and/or Torres Strait Islander	☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither ☐ Unknown		
Country of Birth		Cultural Identity	
Main language spoken at home			
Proficiency in spoken English	☐ Very well ☐ Well ☐ Not Well ☐ Not at all		

DESCRIPTION OF PRESENTING COMPLAINT(S)/PROBLEM(S): Please provide as much information as possible (e.g. psychological/ emotional/behavioural/physical/social problems, learning difficulties, developmental issues, play or peer issues, family difficulties, parenting/ attachment issues and/or other).
N.B. Please attach additional information or copies of assessments if available.

RISK ASSESSMENT: If risk is high please refer to the Mental Health Access Line on: **1800 011 511**

Suicidal thoughts	☐ Yes ☐ No	Suicidal intent	☐ Yes ☐ No
Current plan	☐ Yes ☐ No	Risk of harm from others	☐ Yes ☐ No
Risk of non-suicidal self-harm	☐ Yes ☐ No	Other child protection concerns	☐ Yes ☐ No

If answer is "yes' please explain:

PARENT/GUARDIAN DETAILS:

First Name		Last Name	
Phone 1		Phone 2	
Relation			

SCHOOL DETAILS:

Name of School		Grade	
Is someone at school involved in the child's care?	☐ Yes ☐ No ***(if so, please provide details below)***		
Name		Position	

PARENT/CARER PREFERRED PSS PROVIDER NAME: (Subject to availability and may be left blank)
Directory available at https://www.cesphn.org.au/directories-search-form

1.	
2.	

PARENT/CARER CONSENT: *Referral cannot proceed without parent/carer consent*

☐ *Referrer confirms that the client consents to the following:*

- Client understands and agrees to the above PSS referral
- Client agrees to their clinical and non-clinical information being shared with the PSS Provider Organisation and Mental Health Professional that their referral is allocated to
- Client understands that they will be contacted by the allocated PSS Provider Organisation or Mental Health Professional to arrange an appointment
- Client agrees to their clinical and non-clinical information being shared with CESPHN for administrative and project evaluation purposes
- Client agrees to their anonymised data being shared for administrative and project evaluation purposes
- Client understands that they may be contacted by CESPHN or its representative to complete a client experience of care survey

REFERRER SIGNATURE:		**DATE:**	/ /