**North Coast Region – Student Wellbeing Program Referral**

**School:**

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| The role of the Wellbeing Professional is to provide therapeutic intervention to students displaying mild to moderate mental health concerns. A Wellbeing Professional could be a Psychologist, Guidance Officer or a Social Worker. | | | |
| Student details | | | |
| **Full Name:**  **DOB:** | | | **Year Level**:  **Gender:**   Male  Female  Other |
| Parent/carer details | | | |
| **Name:**  **Is aware of the referral** No  Yes | | | **Relationship to student:** |
| Referrer details | | | |
| **Full Name:** | | | **Role:** |
| **Work Phone/Email:** | | | |
| Referral details | | | |
| **What are your main concerns?**  If more than one concern, please rank in order of most concerned to least (ie 1 – 3). | | Anxiety  Family Stressors  School refusal  Depression  Trauma  Self-harm  Social/ Emotional  Grief and Loss  Other:  Anger/ Aggression  Body image/ Disordered eating  Additional notes: | |
| **Is the student a risk to themself or others?**  No  Yes | | Suicidal Ideation  Self Harm  Aggression  Threats  Risk:  Mild  Moderate  High  Severe | |
| **Current mental health supports/ barriers to accessing support** | | | |
| **Student currently receives support from?** | Child & Youth Mental Health (CYMHS)  Private Psychologist/ Counselling  Headspace  On waitlist for external services - estimated time:  Other:  None (please note barriers to accessing support): | | |
| **Additional Comments:** | | | |
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|  | | | |
| **Signatures** | | | |
| **I, (Parent/Carer/Student) hereby agree to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ being referred to the Wellbeing Professional.**  **(Parent/ Carer/ Student) Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_**  **OR Verbal consent was obtained from (Parent/ Carer/ Student): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_on:\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Date)**  **By:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Person obtaining the verbal consent).** | | | |
| **Referrer’s Signature: \_\_\_\_\_\_\_\_\_\_ Name: Date:** | | | |
| **Principal/Delegate’s Signature: \_\_\_\_\_\_\_\_\_\_ Name: Date:** | | | |