**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:** |
|  |
|  |
| **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:** |