YOUTH HEALTH TEAM REFERRAL FORM

SERVICE INFORMATION AND ELIGIBILTY CRITERIA

Youth Health Team (YHT) provide a free and confidential health service to young people aged 12-18 years. We aim to improve the health outcomes of young people with complex health and social needs.

The target group is young people who are marginalised, disadvantaged or at risk of poor health outcomes, with a particular focus on young people who are **homeless or at risk of homelessness.**

To be eligible the young person must frequent/live/ work/ study within the Newcastle, Lake Macquarie and Port Stephens areas.

We provide short term intervention that involves youth specific assessment and triage of presenting health issues.

This includes:

General Health- Medical assessment and treatment with a Paediatrician, linking with other health providers, e.g. General practitioners, dentists, optometrists, follow up on discharge from hospital

Behaviour, Development and Learning Concerns – Assessment and treatment with a Paediatrician with the capacity to provide ongoing paediatric review if necessary

Sexual Health- Education, contraceptive support and advice, STI screening and pregnancy options

Substance Misuse- Screening, education and referral to Alcohol & Other Drug support and treatment services

Mental Health - We screen for emerging mental health concerns as part of our assessment and refer to mental health services as appropriate. We do not provide mental health counselling support or treatment.

Staff-

Clinical Nurse Consultant, Social Worker, Staff Specialist Paediatrician and Clerical Support

THE YOUTH HEALTH TEAM IS BASED AT:

621 Hunter street Newcastle – PH: 49257804.

We also provide outreach to selected areas

Please email this Form to: HNELHD-YHT@health.nsw.gov.au or FAX to: **49257955**

Community Health Services
CHILDREN, YOUNG PEOPLE AND FAMILIES

NSW GOVERNMENT Health
Hunter New England Local Health District

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- Is this young person homeless or at risk of homelessness? Yes ☐ No ☐
- Does the young person consent for the YHT to contact the referrer to access information which may assist in the assessment of this referral? Yes ☐ No ☐
- Does this young person have support from family or carers? Yes ☐ No ☐
- Does the young person consent to this referral? Yes ☐ No* ☐

If you do not have consent, please contact the Youth Health Team (49257804) to discuss prior to making a referral.

YOUNG PERSON BEING REFERRED (* COMPULSORY FIELDS)

***Given Names:**	***Surname:**	
***Date of Birth:**	**Current age:**	
***Gender:**	**Preferred Name:**	
***Address:**	**Suburb:**	**Postcode:**
***Phone Number**:	***Email:**	
***Medicare No:**	**Position on card:** **Expiry:**	**Health MRN :**
***Cultural Identity:** Aboriginal: ☐ Torres Strait Islander: ☐ Both ☐		
Culturally & Linguistically Diverse: ☐	**Country of Birth:**	
Language:		
Occupation:		
Student: ☐	**School:**	**Year:**

PLEASE PROVIDE DETAILS OF AN EMERGENCY CONTACT PERSON

Given Names:	**Surname:**
Relationship to client:	**Next of Kin** ☐
Able to contact: YES ☐ **NO** ☐	
Home / Work Phone:	**Mobile:**

DOES THE YOUNG PERSON HAVE A REGULAR GENERAL PRACTITIONER OR MEDICATIONS?

Yes ☐ **No** ☐

If **YES** – please complete the following:

GP / Doctor Name:	
Address:	
Medications :	

DOES THE YOUNG PERSON PREFER TO SEE STAFF OF A PARTICULAR GENDER?

Yes ☐ **No** ☒ **Don't Know** ☐ **if yes, please specify:**

REFERRER DETAILS (* COMPULSORY FIELD)

***Date:**	
***Contact Name**:	
***Position / Relationship:**	
Organisation (if applicable):	
***Phone:**	**Mobile**:
***Email:**	

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REASON FOR REFERRAL (If selected please expand below)

Accommodation / Homelessness	☐	Mental Health Concerns	☐
Access to other services	☐	Physical Health	☐
Access to Paediatrician	☐	Developmental concerns	☐
Alcohol &/or Drugs	☐	Pregnancy	☐
Anger Management	☐	Relationships	☐
Bullying	☐	Sexual Health	☐
Behaviour Concerns	☐	Sexuality	☐
Child Protection	☐	Smoking	☐
Contraception Options	☐	Sleep difficulties	☐
Domestic Violence	☐	Weight	☐
Education difficulties	☐	Other: (please specify)	☐

***Brief description of current situation:**
***Expectations of referral:**

THANK YOU FOR YOUR REFERRAL THE YOUNG PERSON IS USUALLY CONTACTED WITHIN 2 WEEKS

YHT USE ONLY:

Allocation SW ☐ CNC ☐ DR ☐ Not Accepted ☐ DVRS: Yes ☐No ☐