# **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 and/or have limited support from carers.**

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-** Support with linking with health providers, e.g. Medical specialists, general practitioners, dentists, optometrists, follow up on discharge from hospital

**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-YouthHealthTeam@health.nsw.gov.au** or FAX to: **49257955**

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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 limited to no support from family or carers?

 Yes [ ]  No [ ]

* Does the young person consent to this referral? Yes [ ]  No [ ]

***\*If you have answered no to any of the above, please contact the Youth Health Team (49257804) to discuss prior to making a referral.***

## **YOUNG PERSON BEING REFERRED** (\* Compulsory FieldS)

|  |
| --- |
| **\*Given Names:** Click here to enter text. \***Surname:** Click here to enter text. |
| **\*Date of Birth:** Click here to enter a date.**Current age:** Click here to enter text. |
| **\*Gender:** Click here to enter text. **Pronoun:** Click here to enter text. |
| **\*Address:** Click here to enter text. **Suburb:** Click here to enter text. **Postcode:** Click here to enter text.  |
| **\*Phone Number**: Click here to enter text. \***Email:** Click here to enter text. |
| \***Medicare No:­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­** Click here to enter text. **\*Position on card:** Click here to enter text.**\*Expiry:** Click here to enter text.  |
| **\*Cultural Identity:** Aboriginal**:** [ ] Torres Strait Islander**:** [ ] Both[ ] Prefer not to say  |
| **Culturally & Linguistically Diverse:** [ ]  **Country of Birth:** Click here to enter text. |
| **Language:** Click here to enter text. |
| **Student:** [ ]  | **School:**Click here to enter text. | **Year:**  |

## **PLEASE PROVIDE DETAILS OF AN EMERGENCY CONTACT PERSON**

|  |
| --- |
| **Given Names:** Click here to enter text. **Surname:** Click here to enter text. |
| **Relationship to client:** Click here to enter text. **Next of Kin** [ ]   |
| **Able to contact:** **YES** [ ]  **NO** [ ]  **Phone:** Click here to enter text. |

##  **DOES THE YOUNG PERSON HAVE A REGULAR GENERAL PRACTITIONER Or Medications?**

**Yes** [ ]  **No** [ ]

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

|  |  |
| --- | --- |
| **GP / Doctor Name:**  | Click here to enter text. |
| **Address:**  | Click here to enter text. |
| **Medications :**  | Click here to enter text. |

##  **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**: Click here to enter text. |
| **\*Position and organisation:** Click here to enter text. |
| **\*Phone:** Click here to enter text. |  |
| **\*Email:** Click here to enter text.  |

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## **rEASON FOR REFERRAL (If selected please expand below)**

|  |  |
| --- | --- |
| Accommodation / Homelessness | Click here to enter text. |
| Access to other services | Click here to enter text. |
| Alcohol and Other Drugs | Click here to enter text. |
| Behaviour Concerns | Click here to enter text. |
| Child Protection | Click here to enter text. |
| Domestic Violence | Click here to enter text. |
| Developmental concerns | Click here to enter text. |
| Education difficulties | Click here to enter text. |
| Mental Health Concerns | Click here to enter text. |
| Physical Health | Click here to enter text. |
| Sexual Health | Click here to enter text. |
| Other: (please specify) | Click here to enter text. |

|  |
| --- |
| **\*Brief description of current situation:**Click here to enter text. |
| **\*Expectations of referral:** Click here to enter text. |

## **Thank you for your referral The Young Person is usually contacted within 4 weeks**

# YHT USE ONLY:

Allocation SW [ ]  CNC [ ]  DR [ ]  Not Accepted [ ]  DVRS: Yes [ ] No [ ]