

**INTAKE AND REFERRAL FORM**  
*Fax to Litmus on 02 6254 1967*

**1. Intake Details**

Referred by: .....Agency and Role:.....  
 Intake completed by:.....Date referred: .../.../...Phone:.....Fax:.....  
 Who is the primary client you are referring? Young Carer  Family Team

**2. Family Team Details**

**Consent to share Young Carer details:**

Written Consent  Date:.....Period of consent 1 week/1 month/3 months  
 Young Carer Name:.....Signature.....Date.../.../...  
 Worker Name:..... Signature.....Date.../.../...

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Young Carer Name ..... Gender: Female  Male   
 DOB: ...../...../.....Age:.....Address:.....  
 Ethnicity: Aboriginal/Torres Straight Islander  Culturally and Linguistically Diverse  Other   
 CALD/ other – specify:..... School: .....Grade: .....  
 Language Spoken at Home: English  Other  If Other, please specify:.....  
 Phone: Home – ..... Mobile – .....  
 Email:.....preferred method of contact.....  
 Caring responsibilities:.....

**Consent to share Parents details:**

Written Consent  Date:.....Period of consent 1 week/1 month/3 months-  
 Parents Name:.....Signature.....Date.../.../...  
 Worker Name:..... Signature.....Date.../.../...

**If you don't have consent please leave this section blank**

Parents Name:..... Mother  Father  Age:.....  
 Ethnicity: Aboriginal/Torres Straight Islander  Culturally and Linguistically Diverse  Other   
 CALD/ other – specify:..... Is an Interpreter Needed ? Yes  No  Language:.....  
 Is the Mental Illness: Diagnosed Yes  No  Diagnoses:.....

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Undiagnosed Yes  No  Indicators:.....

**3.The Referral – Triage**

*Please complete this section as thoroughly as possible – Your professional comment is invaluable*

Why are you referring to Litmus? .....

.....

How can Litmus provide support?.....

.....

**Referring Agency:** Please indicate with a tick where you think the young carer and / or the family team sits on the continuum below ✓

**Young Carer/Family Team member:** Indicate with a circle where you feel that your family sit on the continuum below ○



What level of understanding / insight do the family team / affected person have into their mental health? .....

.....

Are there specific areas of concern / Risk Indicators / mental health diagnosis?.....

.....

Diagnosis made by (Doctors name): .....

Is the family currently accessing mental health services? Yes  No  If yes, details:

.....

.....

Is there a current case manager? Yes  No  If yes, details:

Name: ..... Agency: ..... Contact: .....

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Is the family accessing any other services? Yes  No  If yes, details:.....  
 .....

Are there any other issues/ information? Yes  No  If yes, details:.....  
 .....  
 .....

Can Litmus Contact the family team directly?  
 Yes  No  If yes, details:

**Anglicare Canberra Goulburn, Litmus Program Use Only**

Date presented at Intake meeting: ..... /..... / .....

Outcome of Intake meeting: .....

a) If allocated: Date: ..... /..... / ..... Allocated: Yes  No  Waiting List   
 Allocated to: \_\_\_\_\_ First visit date: ..... /..... / .....

b) If referral not accepted, please detail reason and what, if any, action was taken?  
 .....  
 .....  
 .....