

INTAKE AND REFERRAL FORM
Fax to Litmus on 02 6232 2424

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.../.../...

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:.....

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Is the Mental Illness: Diagnosed Yes No Diagnoses:.....
 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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Anglicare Canberra Goulburn
Litmus intake and referral form



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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?
.....
.....
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