Government of South Australia
SA Health

Youth Health Service

Non-urgent fax referral

Elizabeth fax: 8255 3155
Christies Beach fax: 8326 7232
Talking Realities fax: 8243 5549

Service criteria 1: aged 12 to 25 years (please circle)

YES / NO Under Guardianship of the Minister (past or present)
YES / NO Aboriginal and/or Torres Strait Islander
YES / NO In the Adelaide Youth Training Centre (past or present)
YES / NO Young pregnant and/or parenting woman and their partners
- > Clinical health care
- > Talking Realities

YES / NO Refugee
YES / NO Homeless
YES / NO Newly identifying as same sex attracted, transgender and /or gender questioning

Service criteria 2: having difficulty managing their own health care needs

YES / NO

CLINICAL RESPONSIBILITY REMAINS WITH REFERRER UNTIL ACCEPTED AS A CLIENT BY THE YOUTH HEALTH SERVICE

REFERRER'S DETAILS

Name: _____ Agency:_____

Referrer's address: _____

Suburb: _____ Postcode: _____

Phone number: _____ Email: _____ Fax:_____

Does the young person consent to the referral? Yes ☐ No ☐ Date referred: _____

YOUNG PERSON'S DETAILS

Surname: _____ Given names: _____

Address: _____

Suburb: _____ Postcode: _____ Date of birth: _____

Phone number: (H) _____ (Mobile) _____ Email: _____

Preferred contact method (please circle one): home phone / mobile / email / letter

Medicare number:_____ Health Card/Pension number: _____

Interpreter required: Yes ☐ No ☐ Language: _____

ANY OTHER SERVICES INVOLVED (For example: GP, Mental Health Service etc.)

Name: _____ Service:_____ Phone number: _____

Name: _____ Service:_____ Phone number: _____

Name: _____ Service:_____ Phone number: _____

NEXT OF KIN / GUARDIAN

Name: _____ Relationship to the young person: _____

Address: _____

Suburb: _____ Postcode: _____

Phone number: (H) _____ (W) _____ (Mobile) _____

Interpreter required: Yes ☐ No ☐ Language: _____

REASON FOR REFERRAL

OFFICE USE ONLY

Date received: _____ Date accepted: _____ Date actioned: _____

Accepted: **Yes/No** If n**o** please explain: _____

Attempted contact dates: (1) _____ (2) _____ (3) _____

PLEASE COMPLETE THIS PAGE ONLY IF INFORMATION IS KNOWN

SURNAME: GIVEN NAME:

UR NUMBER:

MEDICAL HISTORY (Diagnosis, admissions, family history, treatment history)

CURRENT MEDICATION	DOSE	DATE INITIATED	RESPONSE (allergies, side effects, compliance)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ALLERGIES / ALERTS / SAFETY ISSUES

MENTAL HEALTH ISSUES

DRUG / ALCOHOL ISSUES

LEGAL / FORENSIC ISSUES

LIVING / SOCIAL AND FINANCIAL SITUATION

CULTURAL / RELIGIOUS ISSUES

DEPENDENTS (children/elders, services involved)

REFERRER'S NAME _____ DESIGNATION _____ SIGNATURE _____

More information

For assistance with completing this form please phone:
Elizabeth: 8255 3477 Christies Beach: 8326 6053 Talking Realities: 8243 5494

Completed forms for non-urgent referrals to be returned via fax (fax numbers on previous page).

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