Parent/Caregiver Referral Form: Student Support Services

On completion of this form, please email directly to sss@fernygroveshs.eq.edu.au

Important information regarding your referral, please read:

- A 'receipt of contact' will be sent to you following your referral
- Suitability of support will be determined once Student Support Services has received your completed Referral Form

URGENT: If your student is experiencing circumstances of **URGENT** concern and that will affect their ability to engage in their school day, please consider engaging your GP or treating practitioner in the first instance.

Date of Referral:	

Referral Information

Student Name:	
Year Level:	
School-based Case Manager (if applicable)**:**	
Referred by (parent/caregiver)**:**	

Consent for Referral:	**Please identify**	
Has the student consented to the exchange of information in relation to this referral?	☐ **Yes**	☐ **No**

Please identify one below in relation to the degree of urgency:

☐ **HIGH PRIORITY:** Student needs to be seen within the next few days **(e.g. Mental health issues impacting on education)**

☐ **AT RISK:** Student at risk of disengaging from school **(e.g. truancy, academic performance, behavioural issues, absenteeism)**

☐ **ROUTINE:** Student needs to be seen within next two weeks **(e.g. goal setting, time management)**

Reason for Referral please provide a brief outline of reason for referral

(e.g. duration, relevant/ pre existing diagnoses)

Nature of Referral please identify all relevant

Career	☐ subject selection ☐ pathway options ☐ tertiary study	**Social/ Emotional**	☐ peer relationships ☐ connectedness ☐ basic family relationship issues ☐ bullying
Educational	☐ subject changes ☐ flexible learning arrangements ☐ cognitive assessments	**Physical Health**	☐ health concerns ☐ alcohol/drugs ☐ healthy eating ☐ sexual health ☐ exercise/sleep ☐ diversity
Personal	☐ complex family issues ☐ grief and loss ☐ complex personal issues	**Mental Health and Wellbeing**	☐ stress and coping ☐ traumatic event ☐ self-harm ☐ suicidal ideation
Spiritual/ Cultural	☐ cultural differences ☐ sense of belonging ☐ spiritual issues ☐ beliefs/values systems	**Other** (Please provide details)	☐ _____

Previous/ current engagement with External Support Services (e.g. Psychologist, Counsellor)	☐ **Yes**	☐ **No**

If yes, please provide details:

Parent/ Caregiver's Signature:

By signing this document, you are acknowledging that the above information is a true and accurate record.

Date: