Self Referral form

### About Step Thru Care

Step Thru Care - Geelong Otway’s offers free mental health and/or alcohol and drug (AOD) support. Step Thru Care provides support in one place, which

means people experiencing mental health or substance use challenges, or a combination of both, don’t need to retell their stories to multiple services.

The Step Thru Care team have diverse backgrounds and expertise, including specialising in mental health, AOD and LGBTIQA+ specific challenges. This helps to create a culturally safe, accessible and inclusive service.

The team is made up of mental health and AOD clinicians, child and family practitioners, multicultural practitioners, care recovery coordinators, and peer support workers who have lived experience of mental health and substance use challenges.

Step Thru Care offers a recovery focused approach by providing:

* Tailored information
* education
* group therapies
* emotional support
* evidence-based therapies
* care coordination

### Eligibility Information

People who are eligible:

* Low income, e.g. healthcare/concession card holders
* Living rural or remote
* People who identify as LGBTQIA+, aboriginal and/or Torres Strait Islander peoples
* People from Culturally and Linguistic (CALD) backgrounds
* Children under the age of 12 years
* People experiencing perinatal depression
* People experiencing or at risk of domestic violence
* People with an intellectual disability and who are experiencing AOD and/or mental health issues
* Young people who do not access to other appropriate services.

Receiving STC service is not duplicative of other services.

Those who do not fit into the above criteria will be encouraged to seek appropriate services.

Please note: people aged 12–25 should seek support from headspace in the first instance.

**Please attach any relevant information to this referral e.g. GP letter, assessments, K10.**

### Consumer Information

|  |  |  |
| --- | --- | --- |
| Title e.g. Mr |  | First Name [Insert first name] |
| Preferred Name [Insert preferred name] |  | Last Name [Insert last name] |
| Date of Birth 1/1/2024 |  | Gender [Insert gender] |
| Pronoun e.g. She / her |  | Address [Insert home address] |
| Contact Number 0400 000 000 |  | Email [Insert email address] |
| Country of Birth e.g. Iran |  | Main Language Spoken e.g. Farsi |
| English Proficiency |  | Interpreter Required  Yes   No |
| ATSI Status |  | Homelessness |
| Intersex |  | Sexual Orientation |
| Labour Force Status |  | Employment Participation |
| Income Source |  | Marital Status |
| Health Care Card  Yes   No |  | NDIS Participant  Yes   No |
| Consent to Share information with  WestVicPHN (Funding body)  Yes   No |  |  |

### Emergency or Support Person Contact

|  |  |  |
| --- | --- | --- |
| First Name [Insert first name] |  | Last Name [Insert last name] |
| Contact Number 0400 000 000 |  | Relationship to You [Insert relationship] |
| First Name [Insert first name] |  | Last Name [Insert last name] |
| Contact Number 0400 000 000 |  | Relationship to You [Insert relationship] |

### Current Supports

**Personal**

|  |  |  |  |
| --- | --- | --- | --- |
| Name [Insert name] |  | Contact Number 0400 000 000 |  |

**Service Support**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name [Insert name] |  | Contact Number 0400 000 000 | | |  |
| Email Address [Insert email address] | | |  |

### Child/Youth Referrals

|  |  |  |
| --- | --- | --- |
| Guardian Name [Insert full name] |  | Contact Number 0400 000 000 |
| Does the child/youth reside  with the guardian?  Yes   No |  | If no, where does the child/youth reside? [Insert carer address] |
| Carer Name [Insert full name] |  | Carer Number 0400 000 000 |
| Are there any legal orders? Eg FLC, IVO, DFFH (please attach copies)  Yes   No |  |  |

Comments:

[Insert comments]

|  |  |
| --- | --- |
| Is the child/young person aware this referral is being made?   Yes   No |  |

### Mental Health & AOD

|  |
| --- |
| Do you have a mental health diagnosis |
| Additional diagnosis |
| Past history of mental health concerns [Insert past history of mental health concerns] |
| Current mental health concerns [Insert current mental health concerns] |
| Do you have any legal involvement eg IVO, CCO, FLC orders?  [Please provide details] |
| Where an IVO is in place, who is this pertaining to?  [Please provide details] |

#### Please advise of medications

|  |
| --- |
| Antipsychotics?  Yes  No  Not stated  Unknown |
| Anxiolytics?  Yes  No  Not stated  Unknown |
| Hypnotics?  Yes  No  Not stated  Unknown |
| Antidepressants?  Yes  No  Not stated  Unknown |
| Psychostimulants?  Yes  No  Not stated  Unknown |
| AOD use  Yes  No |
| Primary drug of concern [Insert primary drug of concern] [Quantity] |
| Secondary drug of concern [Insert secondary drug of concern] [Quantity] |

**Reason for Referral**

[Insert reason for referral]

|  |
| --- |
| **Please email referral to** [**stepthrucare@neaminational.org.au**](mailto:stepthrucare@neaminational.org.au?subject=Self%20Referral%20form) **or fax to 03 5229 5286. If you are sending via email, please ensure the document is password protected.** |
| Please note: Step Thru Care is not a crisis service. Please call the Barwon Health ACCESS Team on  1300 094 187 where acute risk is present. |