

Lighthouse, a free mental health treatment service for young people experiencing the impacts of past complex trauma

Eligibility Criteria:

Age 12 - 18

Living on Gold Coast

Adverse Childhood Experiences: Yes Suspected

Symptoms of Complex Trauma: (please tick all that are observed and/or reported)

Emotional Dysregulation

Avoidance

Dissociation

Hypervigilance

Impaired Self Development

Flashbacks

Disorganised Attachment

Nightmares

To assist us in understanding how our service can help the young person, please can you provide a brief overview of how these symptoms / the past negative experiences are impacting the current functioning of the young person (e.g. change in school performance, engaging in problematic coping strategies, problems resulting from adversarial behaviour, decline in social functioning, sleep issues, unstable accommodation, etc.).

Exclusion criteria if a young person is experiencing co-morbid symptoms that will negatively impact engagement in therapeutic work for trauma they will be supported to engage in more appropriate services and invited to re-engage when stabilised. For more information please see our webpage.

Young Person's Details:

First Name	<input type="text"/>
Family Name	<input type="text"/>
Preferred Name	<input type="text"/>
Date of Birth	____/____/____
Gender	<input type="text"/>
Preferred Contact Number	<input type="text"/>
Address	<input type="text"/> <input type="text"/>

Support Person's Details:

Name	<input type="text"/>
Preferred Contact Number	<input type="text"/>
Nature of Relationship to Young Person	<input type="text"/>

Referrer Details:

Name	<input type="text"/>
Referrer's Position	<input type="text"/>
Organisation	<input type="text"/>
Preferred Contact Number	<input type="text"/>
Email	<input type="text"/>
How Did You Hear About Lighthouse?	<input type="text"/>
Current and Ongoing Involvement	<input type="text"/>
Date of Making Referral	____/____/____

Consent:

Please NOTE: Referrals will not be processed without signed consent from the young person.

I am aware that this referral is being made. I understand that I can withdraw from this referral or from the referred service at any time.

I give permission for Lighthouse to use my contact details above for future contact with me. Yes No

I give permission for Lighthouse to use the contact details of the support person named above to organise initial appointments. Yes No

I give permission for Lighthouse to contact the referrer and advise once an appointment has been arranged. Yes No

Signed:_____ Print Name:_____ Date:_____

If under 18 years of age authorisation ideally should be provided by a parent/ guardian, if appropriate.

Parent/Guardian Signed:_____ Print Name:_____ Relationship:_____

**PLEASE ATTACH ANY RELEVANT COLLATERAL INFORMATION AND FAX REFERRAL TO
07 3532 0218 OR EMAIL LIGHTHOUSE@LIVESLIVEDWELL.ORG.AU**