Lighthouse
Lives Lived Well

Referral form

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

Family Name

Preferred Name

Date of Birth _____/_____/_____

Gender

Preferred Contact Number

Address

Support Person's Details:

Name

Preferred Contact Number

Nature of Relationship to Young Person

Referrer Details:

Name

Referrer's Position

Organisation

Preferred Contact Number

Email

How Did You Hear About Lighthouse?

Current and Ongoing Involvement

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 also be provided by a parent/carer/kin, 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