Mental Health Provider Specialities Form

To support the CAREinMIND Intake and Triage team to appropriately allocate mental health referrals to you, please advise your **areas of specialty** (training or extensive experience – **not just interest**) in treating and supporting vulnerable individuals.

|  |  |
| --- | --- |
| **Name:** |  |
| **Organisation (if applicable):** |  |
| **Service Agreement No.** | **S1 ………………..** |

Please select the boxes to indicate your qualifications/skills and interest.

**Age Groups: Trauma/Harm**

Young children 0-11 years Acquired brain injury

Children 12-15 years Adult survivors of sexual abuse

Adolescents 16-18 years Bullying

Young adults 18-25 years Disaster recovery

Adults 25-65 years Domestic violence

Older adults 65+ Post traumatic stress disorder

**Mental Health:** Self harm

Adjustment disorder Sexual abuse

Attention Deficit Hyperactivity Disorder Suicide

Anxiety Victim of crime

Autism Refugees and asylum seekers

Bipolar Disorder Divorce/separation

Dementia **Personal:**

Depression Adoption

Eating Disorders Anger management

Gender dysphoria  Body image

Obsessive-Compulsive disorder Carer support

Panic disorder GLBTIQ

Personality disorders Grief and loss

Phobias Homelessness

Post-natal depression Selective mutism

Psychosis Sexual difficulties

**General Health:** Relationships

Cancer support **Educational:**

Chronic disease management Intellectual disability

Health-related problems Learning difficulties

Pain management  **Work/Community:**

Physical disability  Work stress

Sleeping disorders Workplace bullying

Terminal illness **Legal:**

Weight management Criminal behaviours

**Addictions:**

Alcohol dependence

Drug dependence

Gambling