**Initial Referral Form**

**Referrer’s Details:**

**Date:** ........................... **Referring Agency:**.................................................................................................................

**Referrer’s name, phone # and email:**………………………………………………………………………………………………………..……….

**How long have you known this Y.P?**……………………………………………………………………………………………………………………

**Service required:** Accommodation or Case management:…………………………………………………………………………..

**Client Details:**

**Name:**………………………………………………………………… **Age:**……..… **D.O.B:**…………………… **PH#**:................................

**Gender**: M / F **Current** **Accommodation Status and how long:**…………………………………………………………….

**Aboriginal:** **Y** / N **Torres Strait Islander:**  Y / N **Country of Birth:**.................................................

**Cultural/religious background:...................................................................... P/R to the minister:** Y / N

**Permission given to record Client Information in database:** Y / N

|  |  |  |
| --- | --- | --- |
|  | **Currently** | **Last Week** |
| **Living Arrangements and How long?** (Alone, Family, refuge) |  |  |
| **Main source of income** (Working, Parent, Youth Allowance, Special Benefit) |  |
| **Are they on Centrelink?** |  |
| **Employment** (Fulltime, part time) |  |
| **School attending & year** |  |
| **Current Day Plan if not at school** |  |

**Previous Accommodation**:

**Suburb of last permanent address**:.........................................................**Did they stay here last week:** Y / N

**Reasons and Details for accommodation breakdown: i.e. Domestic violence/ sexual abuse:**

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**Mental and Physical Health:**

**Mental & Physical Health**:.................................................................................................................................

**Diagnosis & Medication**:....................................................................................................................................

**Regular Dr/Psych:** Y / N ..................................................................................................................................

**Drug and Alcohol Use:**

**AOD Issues? (name, substances):** .....................................................................................................................

**Amount of use & frequency**: .............................................................................................................................

**Surrounding issues (e.g. MH/peer group etc).......**...........................................................................................

**Legal Issues**:

**Current orders & conditions:**.............................................................................................................................

**JJ Office/Probation and parole office:.**..............................................................................................................

**Other (Eg: Day Program):....**...........................................................................................................................................

**Other information:**

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 **Intake staff to complete remainder of referral**

**Background Checks:**

**Name of Service:**....................................... **Ph #:**...................................... **Contact:**..........................................

**Dates of stay (if accommodation)**:............................................ **Length of support**:.........................................

**Details INCL. REASON FOR EXIT FROM ACCOMMODATION SERVICE:**..............................................................

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