# Youth Support Referral FORM 2021

Date of Referral \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Client Details

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender Date of Birth \_\_\_\_ Age (at referral)

Address

 Postcode

Telephone / Mobile \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Identifies as Aboriginal [ ]  Torres Strait Islander [ ]  Both [ ]  Neither [ ]

Country of birth Languages spoken at home

Education (School/Year level) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employment (If applicable)

Is the young person a DHHS client? YES [ ]  NO [ ]

*If yes please indicate what type of order the young person is on and any alerts we need to be aware of:*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Referrer Details

Referrer

Relationship to the client

Agency / Organisation

Telephone / mobile

Email address

## Youth Support Referral Information

What type of assistance are you seeking for the young person? *(Please tick)*

[ ]  Youth Services Programs *(type of program)*

[ ]  Youth Support Program *(please provide details below)*

[ ]  Information/Referral to other services *(please indicate what services below)*

What are the presenting needs of the young person you are seeking support for?

What goals or outcomes are desired for the young person within the Youth Support Program? *(Eg links to specialist service, emotional support, engaged in recreational activities, develop coping strategies etc.)\**

Is there any other information we require in order to best support the needs of this young person? (*Eg IVO’s, victim of abuse, health diagnoses, trauma, family dynamics etc.)\**

Does the young person have any special needs / disabilities?

 *\* Attach additional pages if required.*

Household members / Family unit / Significant others:

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Age | Relationship to client | Residing with client?  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Are other services or supports currently involved?YES [ ]  NO [ ]

*(Eg. Child Protection, Youth accommodation, local GP, social/community groups, student welfare, counsellors etc.)*

Please list details of relevant agency, contact person, role:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Organisation | Staff Name  | Role | Contact details | Past /Current  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Will your organisation remain involved with the young person? YES [ ]  NO [ ]  (*If yes in what capacity?)*

**Has the young person given their consent for this referral? \***

YES [x]

NO [ ]

OTHER [ ]  (*please explain*) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *\*please note we are a voluntary service*

**Please Return This Referral To:** **myplace@cardinia.vic.gov.au**