

Referral Form - Youth Wellbeing & Accommodation

Date: _____ Referrer: _____ Service: _____
Phone: _____ Email: _____

- Carlow House Coolock Units Youth Housing Support Service Housing Support Service
 Family Wellbeing Support Service Reconnect Amber Youth Wellness
 My Way Home Safe Steps

Primary Client Details

First Name _____ Last Name _____

Date of Birth: _____ Age _____ Pronouns: _____

Aboriginal status:

- Non-Indigenous Aboriginal Torres Strait Islander Both Aboriginal and Torres Strait Islander

Interpreter Required Yes No Specific Language: _____

Preferred mode of contact Phone Email Text _____

Phone: _____ Email: _____

Cultural Identity: _____ Recognised Disability: _____ Primary Language/s: _____

Address: _____

Suburb: _____ Post code: _____

Full-time Parent Student Working Unemployed Disability Other: _____

Occupation/Course of Study/Educational Institution/School: _____

Client involved with Child Protection (CPFS): _____ If yes, CPFS status: Open Closed Under the care of CEO

Has the primary client provided consent for the referral Yes No

Please note: participation is voluntary so consent from the primary client is required

Parents/Guardians/Partner

Name: _____ Phone: _____ Relationship: _____

Address: _____

Does young person live with the person listed above? Yes No Unsure

Are there any current Custody or Parenting Orders in place? Or any other legal orders? Yes No Unsure

Details: _____

Consent provided by primary client to communicate with parents/guardians/partner: Yes No

If yes, who is the first point of contact: Parent/Guardian Young Person

Emergency Contact if different from above

Name: _____

Relationship to client: _____

Address: _____ Phone: _____

Reason for Referral

What would the client like support with:

What are their presenting concerns, what is going on for them?

What is their background information?

How are they feeling, what is their overall functioning and wellbeing?

What are their strengths and goals?

Are there any current or historical barriers for the young person accessing supports?

Mental health / wellbeing, current and historical:

Are there any suspected or diagnosed mental or physical health concerns. What are their Current Medications?
Please demonstrate: Early Intervention-required for Family Wellbeing Support Service or Clinical Staging 1b or early stage 2 for Amber Youth Wellness

GP Name _____ Phone No. _____

Diagnosis has been administered by a mental health professional or doctor: Yes No Unsure

Treatment plan completed: Yes No Unsure

Mental health related hospital admissions: Yes No Unsure

Please provide details for admission including admission and discharge dates, and interventions on discharge

Current and historical Suicidality

Current or past suicidal ideation: Current Past – within 6 months Past – over 6 months None
Current or past suicidal attempts: Current Past – within 6 months Past – over 6 months None

If yes, please provide details including details for admission including admission and discharge dates, and interventions on discharge : (when, trigger, means, etc)

Current and historical Non-suicidal self-injury

Current or past self-injury: Current Past – within 6 months Past – over 6 months None

Please provide details

Further information

Alcohol and Other Drugs Information. What are they using, how much, how often,

Current or past alcohol and other drug use: Current Past – within 6 months Past – over 6 months None

Any Additional Relevant Information/Documentation to support the referral:

Thoughts of harm to others Current Past – within 6 months Past – over 6 months None

Safety Concerns

High Risk Behaviours – Potential risks to self/others/within the environment:

Legal issues(including VROs, court matters or orders, family court arrangements/unpaid fines/Residential Tenancy Authority breaches):

Other Services

Any other current services or additional referrals. Please provide a summary of support and contact details:

Has the client recently been declined from any services? Yes (please outline why below) No Unsure

Declined services: _____

Accommodation and Housing Support Services ONLY

Current living arrangement/ accommodation history:

Income Source: _____ Income Amount: _____

Outstanding fines: _____ Housing Authority Wait List: _____

Homeswest Debt: _____ Savings: _____

Centrelink Debt: _____ Furniture: _____

Other Debts: _____ Other items: _____

Net income amount after deductions: _____

Children

Name _____	DoB _____	Age _____	Name _____	DoB _____	Age _____
Name _____	DoB _____	Age _____	Name _____	DoB _____	Age _____
Name _____	DoB _____	Age _____	Name _____	DoB _____	Age _____

Child involved with Child Protection (CPFS): Yes No

If yes, CPFS status: Open Closed Under the care of CEO

Please return this form to Youth Triage Officer

Email: yhreferrals@mercyCare.com.au

Ph: 1800 800 046