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|  |  **Alban Place (IYSMSS) – Referral form** |

**Please email this form to:** **Stepney@centacare.org.au**

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| Referral Date:  |  |
| Referring Agency:  |  | Referrer’s Name & Position:  |  |
| Referrer’s Contact Details | Phone: |  | Mobile: |  |
| How did you find out about us?  |  |

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| **Client Information** |
| Given Names: |  |
| Surname: |  |
| Date of Birth: |  | Gender: |  |
| Age: |  | Preferred pronoun: |  |
| Prefer not to say: |  |
| Address: |  |  Post code:  |  |
| **Contact Details** | Phone: |  | Mobile:  |  |
| Is it okay to leave a message on these numbers? [ ]  YES [ ]  NO Is it okay to send an SMS? [ ]  YES [ ]  NO  |
| Household Living Arrangements (e.g. Young person lives alone, with others, partner, children, parents, couch-surfing/homeless) |  |
| Does the young person live in a place they feel safe: [ ]  YES [ ]  NO - If NO, please give a brief reason why not: |
|  |
| Does the young person identify as Aboriginal? [ ]  YES [ ]  NO Does the young person identify as Torres Strait Islander? [ ]  YES [ ]  NO  |
| Country of Birth:  |  | Cultural Background: |  |
| Preferred Language:  |  | Interpreter required?  | [ ]  YES [ ]  NO  |
| **Emergency contact** - Name & Relationship to the client: |  |
| Contact Number: |  |
| Is this person a Support for the young person? [ ]  YES [ ]  NO |

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| **Reason for referral** (e.g. AOD issues including drugs of concern, quantity, frequency of use, method of use, longevity of use) |
| **Drug(s) of Concern** (please provide as much information as possible)

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| [ ]  Alcohol |  |
| [ ]  Cannabis  |  |
| [ ]  Cocaine  |  |
| [ ]  Amphetamine- type stimulants |  |
| [ ]  Ecstasy/MDMA  |  |
| [ ]  Inhalants |  |
| [ ]  Sedatives |  |
| [ ]  Hallucinogens |  |
| [ ]  Opioids |  |
| [ ]  Other  |  |

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| **Mental Health** (Disorder(s) diagnosed, treated or suspected) |
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| **What treatment is the young person currently undertaking?** (e.g. Regular psychology/psychiatry appointments, BPD therapy) |
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| **What medications is the young person currently taking?** (dosage, regularity, longevity) |
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| **Current Suicide ideation/Self Harm Behaviour:** | [ ]  NO [ ]  YES – If YES, Suicide Risk Assessment to be completed. |
| **Previous Suicide ideation/Self Harm?** | [ ]  NO [ ]  YES – If YES, how recent? |
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| **Other Concerns / Supports involved** (e.g. Relationship issues, Family Conflict, Court ordered counselling, Legal issues, other Health conditions, Homelessness, Education/Employment, Financial issues) |
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| **Support service required** |
| **Is the young person interested in:**[ ]  AOD Counselling and Residential Rehabilitation [ ]  AOD Counselling only [ ]  Unsure yet  **\* Where possible we will accommodate an individual’s preference for gender of Counsellor, however, this may not always be possible.**   |
| **Preferred gender of Counsellor:**  |  |
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| **Client consent** |
| The purpose of this consent has been explained to me by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and I give permission to have my personal information shared with IYSMSS for the purposes of referral. I understand that once received, IYSMSS will contact me and also confirm with the referrer the outcome of this follow up. This consent for sharing of information will expire within one month of the referral being received. I understand that sharing my information with ***IYSMSS*** is done with the aim of ensuring I receive the best possible service. |

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| **Client Name** |  |
| **Signature** |  | **Date of consent** |  |
| **Name of Guardian/Carer**(where applicable) |  |
| **Signature** |  | **Date of consent** |  |

**\*Verbal consent should only be used where it is not practicable to obtain written consent.**

*I have discussed how and why certain information about the client may need to be provided to or discussed with other service providers or nominated persons. I am satisfied the client understands the proposed uses and disclosures, and that the client has provided their informed consent for this to occur.*

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| **Reason written consent was not possible:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Name of referrer** |  | **Signature** |  |
| **Position** |  | **Date** |  |