TOWNSVILLE YOUTH HOUSING AND REINTEGRATION SERVICE

641 Ross River Road
Kirwan Qld 4817

Phone: (07) 4723 4172
Fax: (07) 4755 4967

Email: coordinator@tyhars.org.au
Website: www.qldyouthservices.org.au

CLIENT REFERRAL FORM

- ☐ **Referral for the Support Service**
- ☐ **Referral to the After Care Service**

DATE:_____

Source of Referral: _____

Person calling: _____Phone:_____ Mob: _____

Address: _____

Details of Young Person

Name: _____ Relationship to caller: _____

Address: _____

Age:____ DOB:___/___/_____Phone: _____ Mobile: _____

- ☐ School _____Completing Year_____
- ☐ Employment /Training_____

Does the young person identify as: ☐ Aboriginal ☐ TSI ☐ Other: _____

Basic Issues: (Please tick)

- ☐ Child Protection Services /Orders
- ☐ Youth Justice Involvement/Orders(Pre release referral)
- ☐ Case Plan obtained from Youth Justice/Child Services
  (Current support needs. Service history. Risk of harm and protective factors. Client family, kin, friendships. Community supports. Progress and outcomes
- ☐ Conflict with parents
- ☐ Are there Family and Supports in place? List:
  _____
- ☐ School Issues
- ☐ Mental /Health Issues
- ☐ Disability
- ☐ Client housing Status:
  (Sleeping rough, unstable, temporary housing, homeless)
- ☐ Consent obtained from young person_____
- ☐ Other services involved (Please list)
  _____
- ☐ Risk of harm and Protective Factors
  _____

Outline of current needs

_____

_____

- ☐ Name of person completing referral _____
- ☐ Date Referral was confirmed with referrer _____
- ☐ Referral form photocopied and put in folder
- ☐ Inappropriate Referral/ Referred on to _____

CONFIDENTIAL