

Calvary Youth Services – Referral form.

Client's Name: _____

D.O.B: _____

Referring Agency: _____

Name: _____

Contact Number: _____

Email: _____

Is the client under the care of the CEO?

Yes

No

Is the client an Open Case with DCP?

Yes

No

Reason for referral: _____

Present accommodation: _____

How long at this accom: _____

Client's Information

Violence – Any history of verbal, physical or sexual violence? (Please give details include if Police involvement has been required).

Background Information:

Current mental health issues: (include any diagnosis and treatment being received)

Past mental health issues:

Is the young person currently connected to/or referred to a mental health service? Yes No
Please provide details, status of referral and/or treatment, key contacts.

Who is prescribing the young persons medication? (please include/provide a current and detailed list of young person medication and regime)

Who is the young person's psychiatrist: (please detail the nature of this relationship eg. Frequency of contact)

Name of GP:

Contact details:

Has the client had a recent general health check?

Do they need one?
Current risk assessment: (include self harm, suicide ideation, recent presentation to hospital, factors that increase risk, risk toward other people)
Other Information: (e.g. protective factors, attending counselling, other supports)
What will the young person be doing with their time (attending school, training, work)
Any drug/alcohol issues? (include history)

Medication and Medical				
Is there any prescribed medication?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
If yes, what is the medication?				
And what is it for?				
Is the medication in the labelled box with dose and client's name?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Does the person administer their own medication?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Is assistance required?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

Current Assessment
What is the assessment by your Department of the young person's current situation and risk to: Themselves:
Other Calvary residents:
Calvary staff:

Additional Information:
Behaviours of concern:

Does the young person give their permission to share this information with Calvary Youth Services?

Client's Name: _____ **Signature:** _____ **Date:** / /

Workers Name: _____ **Signature:** _____ **Date:** / /

Once completed, please fax to the Duty Youth Support Worker on (08) 9535 5874 or
Email to youthworker@calvaryyouth.com.au