Email: youthplace@stpats.com.au
Phone (08) 9430 4159

Youth Place Referral Form

Referring Agency Information

Name of referring Agency: _____

Name of referring Worker/Role: _____

Date of referral: _____

Phone number: _____

Email: _____

Client details

Client consent obtained and attached? Please send through written authority with this referral form.

☐ Verbal consent provided ☐ Yes, authority attached

Client Information

Client Name: _____

Address: _____ **Post Code:** _____

Date of Birth: _____ **Age:** _____

Gender: ◉ Male ○ Female ○ Transgender ○ Not specified

Other _____

Contact number: _____ **E-mail:** _____

Partners Name: _____

Date of Birth: _____ **Age:** _____

Gender: ◉ Male ○ Female ○ Transgender ○ Not specified

Other _____

Partners number: _____ **E-mail:** _____

Version Control

Version #	Author	Change	Date approved
1	MCS	Initial approval of Form	2018
2	MCS	Receival date added, phone number updated, inclusion of pets, inclusion of other service providers	04/2020

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Family Information

Number of children: _____

1	Gender	Male ○ Female ○		Age _____	D.o.B	_____
2	Gender	Male ○ Female ○		Age _____	D.o.B	_____
3	Gender	Male ○ Female ○		Age _____	D.o.B	_____
4	Gender	Male ○ Female ○		Age _____	D.o.B	_____

Do you have pets? Yes ○ No ○

If yes, how many? _____

What breed/s? _____

If CaLD – country: _____ **Year of arrival:** _____

Current Accommodation

If evicted, provide information

Source of income

Youth Allowance	☐	New Start	☐	DSP	☐
Wage	☐	No income	☐	PP	☐

If employed, Employer details

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Alcohol / Drug history

Is the client currently using drugs or alcohol? Yes ◉ No ○

If Yes, please provide details / treatment

Psychiatric / Psychological

Does the Client have a mental health diagnosis? Yes ○ No ○

If Yes, please provide details / treatment

History of Suicide /self-harm? Yes ○ No ○ Unknown ○

If Yes, please provide details

Name of GP / Medical clinic / Caseworker: _____

Phone number of Dr / Clinic / Caseworker: _____

Support Serviced involved

Is the young person linked with other support services? Yes ○ No ○

If Yes, please provide contact details / service or treatment received

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Domestic /Family Violence Issues

Any known previous aggression or violence in the family/partner Yes ◯ No ◯ Unknown ◯

If Yes, please provide details

Legal History

Is the client currently on probation or parole Yes ◯ No ◯ Unknown ◯

If Yes, please provide details

Has there been any previous convictions? Yes ◯ No ◯ Unknown ◯

If Yes, please provide details

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CaLD Clients

Cultural background of client:				
Does the Client have refugee status?	Yes ☐	No ☐	**If Yes year of arrival:**	
Main language spoken at home:				

Additional information / safety concerns / issues

Client requires assistance with communication or an interpreter?

Yes - interpreter ☐

Yes – limited English ☐

No ☐

Other

Any other additional information?

Client consent to being referred to St Patrick's Youth Place Program	Yes ☐	No ☐
Client consent to St Patrick's contacting the referring agency named in this form	Yes ☐	No ☐
Client consent to the information on this form being kept as a record of my details	Yes ☐	No ☐