Young Person/Carer Self-Referral Form

Referral Date: **Entered By:**

Young Person's Details

Full Name: _____ **Previous client?** yes ☐ no ☐ unk ☐

Date of Birth: _____ **Age:** _____ **Gender:** Male ☐ Female ☐ Non-Binary ☐ Transgender ☐

Client Address: _____

Contact Number*(s)*: _____ **Email:** _____

Centrelink Status:

Unemployment Benefit ☐ Disability Support Pension ☐ Sickness Benefit ☐ Youth Allowance ☐ Student ☐

Other *(please specify)* ☐ _____ No Benefits ☐

Aboriginal or Torres Strait Islander? Yes ☐ No ☐ **Country of Birth** _____

Client's Key Contact Person *(in case of emergency)*

Name: _____ Relationship to young person: _____

Contact Number(*s*): _____

Address: _____

Referrer's Details *Please tick if self-referring:* ☐

Referrer Full Name: _____ **Contact Number:** _____

Email Address: _____

Workplace: _____

Is the young person involved in any Legal Issues? Yes ☐ No ☐

Reason for Referral *(What is the main problem that the young person is seeking help with?) Triage will call to gain further information about this*

_____

_____

_____

_____

_____

_____

_____

_____

Other Information

Does the young person have an existing GP? Yes ☐ No ☐ *(If yes, please fill in the details below)*

Doctor's Name: _____

Practice Name: _____ Phone:_____

Medicare Details (*include position and expiry date*): _____

Consent **Client is aware of referral and has given consent: Yes ☐ No ☐**

******PRIVACY******

If the young person does not want their parents or carers to know about them accessing our services, please let us know and we will note this on their file. (*Young people aged **under 16** years need to have a responsible adult involved*)

Doesn't Mind ☐ Keep Private ☐