Clarence Street - Referral Form

Client Details:

Preferred Name: ……

Legal Name: ……..……...

Address: ……

Suburb: ……..…….. Post Code: ……..…

D.O.B: ……../……/…… Age: ……

Contact number: ….……

Ok to leave message ☐ Yes ☐ No

Email: ……..

Country of birth: ☐Australia ☐Other:……..

Is the client of Aboriginal or Torres Strait Islander origin...

- ☐ No
- ☐ Yes, Aboriginal
- ☐ Yes, Torres Strait Islander
- ☐ Yes, Both Aboriginal and Torres Strait Islander
- ☐ Decline to answer

Does the client identify as culturally & linguistically diverse?

- ☐ Yes specify: ……..…….....
- ☐ No

Is English the clients family's main language spoken at home?

- ☐ Yes
- ☐ No specify: ……...…….....

Gender assigned at birth: ☐ Male ☐ Female

Is the client a member of the LGBTQA+ community?

- ☐ Yes specify: ……...…….....
- ☐ No
- ☐ Not disclosed / unsure

Parent/Guardian/Significant Other:

Preferred Name: ……

Legal Name: ……..……..

Contact number: ……

Relationship to client: ……

D.O.B: ……/……/…..… (if referral is for family work)

Are family members aware of referral? ☐ Yes ☐ No

Referrer Details

Name: ……..

Organisation: ……

Address: ……..

……..……

Contact number: ……

Email: ……..

Relationship to client: ……

Reason for Referral

Service requested

☐ Drop In Service ☐ Family Work ☐ Pivot Program ☐ Individual Outreach ☐ Residential Program (ADAWS/THREAD)

Client Consent:

I am aware that this referral is being made. I understand that I can withdraw from this referral or from the referred service at any time. ☐ Yes ☐ No

I give permission for Clarence Street to use my contact details above for further contact with me. ☐ Yes ☐ No

I give permission for Clarence Street to contact the referrer and advise once an appointment has been made. ☐ Yes ☐ No

Print Name: ……..… Signed: ……..…… Date: ……

***If under 16 years of age, where appropriate a parent/ guardian should be informed of referral**

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Presenting Alcohol & Drug Issues/Use (incl. substances used, amounts, frequency, duration and impact of use, previous treatment)

Safety and Risk Issues (incl. self-harm/suicidality/harm to others/harm from others – current and previous)

Mental Health or Health Concerns (incl. diagnosis, current treatment and involved agencies)

Current GP:

GP Name: …… Medical Centre: ……

Contact number: ……

Diagnosis History:

Known Allergies: ☐ Yes ☐ No If yes, explain……..

Known Intellectual Disability: ☐ Yes ☐ No If yes, explain……..

Known Physical Disability: ☐ Yes ☐ No If yes, explain……..

Other Significant Medical Condition: ☐ Yes ☐ No If yes, explain……..

Ongoing Prescribed Medications: ☐ Yes ☐ No If yes, explain……..

Family/Home situation (incl. structure, supports, relationships, accommodation, Child Safety involvement)

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Social issues (incl. education/occupation, legal issues, financial situation, peer relationships, sexuality, cultural/spiritual)

Other agencies/workers involved in the client's care and contact details (incl. Child Safety, Youth Justice etc.)

Organisation: …… Length of time involved: ……

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Completed by (please print name): ……..... …….

Signed……

Date: ……

On receipt of a referral form, Clarence Street will contact the young person to arrange an appointment.

With consent from the young person Clarence Street will advise the referrer of the young persons' appointment time.

Please attach additional relevant information as needed.

Please return this form to Clarence Street:

Clarence Street
36-40 Clarence Street, South Brisbane Queensland 4101
Phone: 07 3163 8400
Fax: 07 3163 2839
Email: clarencestreet@mater.org.au