**Third Party Referral Form**

***Please note:*** *Please complete form electronically or by printing and completing via hand. Use of the electronic functions within this form (e.g. check box) is dependent on the currency of your computer software.*

|  |  |
| --- | --- |
| **REFERRER’S DETAILS** | |
| Date | /       / |
| Name |  |
| Organisation/ School/ Other |  |
| Relationship to Young Person |  |
| Phone Number |  |
| Email Address |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **YOUNG PERSON’S DETAILS** | | | | | | | |
| Name |  | | | | | | |
| Address |  | | | | | | |
| Suburb/Town |  | | Postcode | | | |  |
| Phone 1 |  | | Phone 2 | | | |  |
| DOB | /       / | | Identified Disability | | | |  |
| Gender |  | | Country of Birth | | | |  |
| Cultural Identity | Aboriginal | Torres Strait Islander | | | Anglo  Australian | Other | |
| Language/s and dialect spoken (for interpreting purposes) |  | | | | | | |
| Interpreting Service Required/Requested | Yes | | | No | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **PARENT/CARER DETAILS** | | | | |
| Name |  | | | |
| Relationship to Young Person |  | | | |
| Country of Birth |  | | | |
| Permission to Contact | Yes | | No | |
| Phone 1 |  | Phone 2 | |  |
| Language/s and dialect spoken (for interpreting purposes) |  | | | |
| Interpreting Service Required/Requested | Yes | | No | |

|  |
| --- |
| **PRIMARY PRESENTING ISSUE (what is the main reason for this referral)** |
|  |

|  |
| --- |
| **ADDITIONAL SUPPORT NEEDS** |
|  |

|  |
| --- |
| **WHAT OUTCOME/S WOULD YOU LIKE TO SEE FROM THIS REFERRAL** |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| **GENERAL INFORMATION** | | |  |
| Is Child Safety Services involved with the young person? | Yes | No | Unknown |
| Is Youth Justice Services involved with the young person? | Yes | No | Unknown |
| Is there conflict between the young person and their parent/carer/s? | Yes | No | Unknown |
| Does the young person have any diagnosed Mental Health issues? | Yes | No | Unknown |
| Does the young person know of this referral? | Yes | No | Unknown |
| Does the young person consent to this referral? | Yes | No | Unknown |
| Has the young person’s Parent/Carer been informed of this referral? | Yes | No | Unknown |

|  |
| --- |
| **OTHER RELEVANT INFORMATION ABOUT THE YOUNG PERSON’S CIRCUMSTANCES** |
|  |

**Please forward ICYS Referral Form to:**

|  |  |  |
| --- | --- | --- |
| **Eligibility** | **Email address** | **Fax** |
| Young person aged 10-15 (primary target age) who has had contact with Police and at risk of offending or reoffending | [cyr@icys.org.au](mailto:cyr@icys.org.au) | (07) 3812 2971 |
| Young person aged 12-21 residing in the greater Ipswich Region | [yss@icys.org.au](mailto:yss@icys.org.au) |
| Young person aged 12-21 residing in the Somerset or Lockyer Valley regions | [yss@icys.org.au](mailto:yss@icys.org.au) |
| Young person aged 16-25 who is homeless or at risk of homelessness | [housingintake@icys.org.au](mailto:housingintake@icys.org.au) |