



INCOMING REFERRAL FORM

Induction Intakes are between 9am-4pm Monday to Friday in the

Dubbo office: 9 – 11 White Street Dubbo NSW 2830

Email: intake@oranasupport.com.au

Phone: 1800 353 199

No inductions are made after 4pm

Date:		Time:		Taken by:	
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Name:		Name:	
Alias:		Alias:	
D.O.B:		D.O.B:	
Gender:		Gender:	
<input type="checkbox"/> Non-Binary/Prefer not to say		<input type="checkbox"/> Non-Binary/Prefer not to say	
Country of birth:		Country of birth:	
Year of arrival:		Year of arrival:	
<input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Neither		<input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Neither	
Cultural identification:		Cultural identification:	
Preferred language:		Preferred language:	
Interpreter required:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Interpreter required:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Address:			
Contact phone:		Emergency contact:	
Email:			
Service required:	<input type="checkbox"/> Accommodation <input type="checkbox"/> Tenancy support	<input type="checkbox"/> Furniture <input type="checkbox"/> Food <input type="checkbox"/> Other	
Has own transport?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you have pets?	<input type="checkbox"/> Yes <input type="checkbox"/> No	How many?	Breeds?

Referral details

Self-referred?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Referral Agency:		Referring Officer:	
Date:	Contact Number:	Signed:	
PLEASE ATTACH ANY CRIMINAL HISTORY, PAROLE CONDITIONS, ADVO'S ETC			

Details of all Family/Individuals who will be residing with client:

Name	M/F	DOB	Age	School	Attending	Relationship

Accompanied Children's Support Service (ACSS)

Would you like your child/children referred to our specialist youth program and receive a call to discuss our children's services and how we could support in more details? Yes No

Currently homeless? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so, for how long?
Reason for homelessness:	
Current location & type of accommodation. E.g. town – couch-surfing, Temporary Accommodation etc.	
Time since last permanent address & location?	
Location & Type of accommodation 1 week ago if different from last permanent address:	

Is this related to a Domestic Violence issue: <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Physical <input type="checkbox"/> Verbal <input type="checkbox"/> Emotional <input type="checkbox"/> Coercive <input type="checkbox"/> Other
Person in Need of <input type="checkbox"/> Protection / <input type="checkbox"/> Perpetrator (check one)
Is there an ADVO in place: <input type="checkbox"/> Yes <input type="checkbox"/> No
Details:
Is it safe to call you on your phone number provided? <input type="checkbox"/> Yes <input type="checkbox"/> No

History

Does anyone need help with: Communication: <input type="checkbox"/> Yes <input type="checkbox"/> No Self Care: <input type="checkbox"/> Yes <input type="checkbox"/> No Mobility: <input type="checkbox"/> Yes <input type="checkbox"/> No
In the past 12 months has anyone on this application been in any facilities / institutions: eg Adult correction facilities, hospital? : <input type="checkbox"/> Yes <input type="checkbox"/> No Details:
Is anyone on this application involved in any legal processes? <input type="checkbox"/> Yes <input type="checkbox"/> No Currently on: <input type="checkbox"/> Probation <input type="checkbox"/> Parole <input type="checkbox"/> Bond <input type="checkbox"/> ADVO <input type="checkbox"/> Bail? Details:
Who do they report to?
Does anyone on this application have a history of Aggression or Violence to others? <input type="checkbox"/> Yes <input type="checkbox"/> No Details:
Does anyone on this application have a disability or Physical medical condition? <input type="checkbox"/> Yes <input type="checkbox"/> No Details:
Does anyone on this application have an NDIS package: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, can you provide NDIS Number: Copy of NDIS plan: <input type="checkbox"/> Yes <input type="checkbox"/> No Who manages Plan: Would you like us to manage the NDIS:
Does anyone on this application have a history of Mental Health: <input type="checkbox"/> Yes <input type="checkbox"/> No Currently being treated? <input type="checkbox"/> Yes <input type="checkbox"/> No Under Control: <input type="checkbox"/> Yes <input type="checkbox"/> No Diagnosis: <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Schitz <input type="checkbox"/> Bi-Polar <input type="checkbox"/> Other
Does the applicant have a Mental Health case manager: <input type="checkbox"/> Yes <input type="checkbox"/> No Details:
Does anyone on this application have a history of self-harming? <input type="checkbox"/> Yes <input type="checkbox"/> No
History of Drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No Currently using? <input type="checkbox"/> Yes <input type="checkbox"/> No Details:
History of Alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No Currently using? <input type="checkbox"/> Yes <input type="checkbox"/> No Details:
Australian Defence Force Member: <input type="checkbox"/> Yes <input type="checkbox"/> No

