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**Turning Tides**

**REFERRAL FORM**

**REFERRAL PROCESS**

1. Phone Allambee on **9535 8263** to discuss potential referral if necessary.
2. Complete Referral Form and email to [referrals@allambee.org.au](mailto:referrals@allambee.org.au) or fax to **9535 3869** with subject area marked “referrals”.
3. Upon receipt of referral an inter-agency meeting will be arranged if necessary.
4. Allambee will phone parent/guardian to complete the triage assessment.
5. Referrer will be contacted if Allambee is unable to contact or engage the client.
6. **Referral will not proceed if consent and safety information is not completed on last page**

**REFERRAL DETAILS**

REFERRAL DATE: Click or tap to enter a date.

AGENCY OR SERVICE: Click or tap here to enter text.

CONTACT PERSON: Click or tap here to enter text. Telephone No: Click or tap here to enter text.

Email Address: Click or tap here to enter text. Fax No. Click or tap here to enter text.

No further involvement:  Click or tap here to enter text.   
Open case:  Click or tap here to enter text.

**CLIENT DETAILS**

Surname: Click or tap here to enter text.

Given Names: Click or tap here to enter text.

Date of Birth: Click or tap to enter a date. Age: Click or tap here to enter text.

Gender: Choose an item.

Preferred Pronouns: Choose an item. Other: please specify: Click or tap here to enter text.

Email Address: Click or tap here to enter text.

Address: Click or tap here to enter text.

Disabilities, Physical Health Concerns, or Mental health Concerns: Click or tap here to enter text.

**CAREGIVER, FAMILY AND ACCOMMODATION DETAILS**

Is the child in the care of the Department of Communities – Child Protection and Family Support?

Yes :  No :

Child is living with:

Both ParentsMother Father SingleParent, Diverse Gender  
Blended FamilyRelative Carer Non-Relative Carer

Other people living with the young person: (please specify ages of any children or other young people in the home) Click or tap here to enter text.

**Caregivers details:**

Name: Click or tap here to enter text.

Relationship to Child: Click or tap here to enter text.

DOB: Click or tap to enter a date.

Telephone No: (H) Click or tap here to enter text. (Mob) Click or tap here to enter text.

Email Address: Click or tap here to enter text.

Address: Click or tap here to enter text.

Permission Given for Allambee to Contact: Yes :  No :

**Caregivers details:**

Name: Click or tap here to enter text.

Relationship to Child: Click or tap here to enter text.

DOB: Click or tap to enter a date.

Telephone No: (H) Click or tap here to enter text. (Mob) Click or tap here to enter text.

Email Address: Click or tap here to enter text.

Address: Click or tap here to enter text.

Permission Given for Allambee to Contact: Yes :  No :

If the child is not living with biological parents, please provide details below:

Biological Mother’s Name: Click or tap here to enter text.

DOB: Click or tap to enter a date.

Telephone No: (H) Click or tap here to enter text. (Mob) Click or tap here to enter text.

Email Address: Click or tap here to enter text.

Address: Click or tap here to enter text.

Biological Father’s Name: Click or tap here to enter text.

DOB: Click or tap to enter a date.

Telephone No: (H) Click or tap here to enter text. (Mob) Click or tap here to enter text.

Email Address: Click or tap here to enter text.

Address: Click or tap here to enter text.

Other key support people or family members: Click or tap here to enter text.

**REASON FOR REFERRAL:**

Description of the harmful sexual behaviour/concerning sexualised behaviours (include if known any information about when the behaviour occurred, how often etc.):

Click or tap here to enter text.

If applicable, please provide details of others involved (e.g. relationship to the young person, ages etc.) Click or tap here to enter text.

Details of steps taken to address/manage the concerning behaviours (e.g. other agency involvement, strategies in place to support safety) Click or tap here to enter text.

**BACKGROUND DETAILS:**

Any barriers to address/barriers to counselling (e.g. intellectual, literacy, psychological, psychiatric, health etc.): Click or tap here to enter text.

Other Services involved (please specify if these services are aware of the concerns leading to referral): Click or tap here to enter text.

Young person’s school/education provider (including year level) and/or workplace: (please specify if they are aware of the concerns leading to referral): Click or tap here to enter text.

Have there been any involvement with Police/legal/justice system in relation to the sexual behaviours:

Yes :  No :  Click or tap here to enter text.

Is the young person subject to any orders or bail conditions or named as a protected person on any restraining orders?: Yes :  No :  Click or tap here to enter text.

Has there been any involvement with Child Protection and Family Support ?:

Yes :  No :  Click or tap here to enter text.

Has the young person or their family experienced family and domestic violence ?:

Yes :  No :  Click or tap here to enter text.

Does the young person or their family have current or historical alcohol or drug use ?:

Yes :  No :  Click or tap here to enter text.

Has the young person been exposed to or experienced any other form of harm (e.g. emotional, psychological, physical abuse) or other trauma (e.g. car accident, death of a loved one, bullying) ?:

Yes :  No :  Click or tap here to enter text.

|  |
| --- |
| **RISK ASSESSMENT:**  **In your opinion, does the client present as a risk to themselves or others?**  **Harm to Self:**  YES  NO  UNSURE  **Harm to Others**:  YES  NO  UNSURE  **Harm from Others**:  YES  NO  UNSURE  **Please provide as much detail as possible to describe the risk** (plan, previous attempt, lethality, intent, means, duration, hopelessness, substance abuse, psych disorder, pain, loss etc.)  Click or tap here to enter text. |
| SAFETY PLAN: Has a safety plan been developed with the client/family in relation to:  Harm to Self:  Harm to Others:  Harm from Others:  Please provide details of the safety plan:  Click or tap here to enter text. |
| **NOTE: IN ORDER FOR THE REFERRAL TO BE PROGRESSED, PLEASE ENSURE THE CONSENT FORM AND SAFETY INFORMATION ON FOLLOWING PAGE IS COMPLETED.** |

**TO BE COMPLETED WITH THE REFERRER**

**Parental/Legal Guardian Consent Form**

This form is to be completed by the young person’s parent/caregiver/legal guardian and includes consent to contact to progress the referral and to share information.

**I**, Click or tap here to enter text.

**Of (address)** Click or tap here to enter text.

give permission for Allambee Counselling to:

- contact me on this number Click or tap here to enter text. to discuss this referral and;

- exchange information with the referrer in relation to myself and/or my children

when necessary to ensure the safety and well-being of family members.

Additionally, I consent to and acknowledge that it is safe for Allambee Counselling to:

- leave messages on the phone number I provided above: Choose an item.

- send text messages to the number I provided above: Choose an item.

- send emails to the email address provided: Choose an item.

- send mail to the address I provided above: Choose an item.

All referrals are reviewed by our multi-agency group to make sure that this is the right service to meet the current needs of the young person and their family/caregivers.

By signing this form, I provide my consent for agencies within the multi-agency group (which may include Child and Adolescent Mental Health Service, Department of Communities (Child Protection and Family Support), and the Department of Education) to share necessary information to achieve the best possible outcome for the young person and their family/caregivers.

I understand I can revoke this consent in writing at any time.

**SIGNATURE ……………………………………………………………..**

**WITNESS………………………………………………………………….**

**DATE ……………………………………………………………………..**

Doc2014: common/forms/counsellor/referral form

**Verbal consent only obtained:**

Name of person providing consent ………………………………………………………….

Name of person completing referral ……………………………………………………….

Signature of person completing referral …………………………………………………….

Date ………………………………………………………………………………………………...