THE JUNCTIONWORKS Ltd
"Creating new possibilities in people's lives"

Office use only

Date received	
Accept	Reject
Response Letter sent	

CM2: CASE MANAGEMENT
REFERRAL FORM

Introduction:
The Junction Works Case Manager's service clients aged 16-65 with a disability in the Liverpool, Camden, Campbelltown, and Wollondilly areas. Clients with a mental health disability, ABI or different age range will be considered on a case by case basis.

Please take the time to complete the form fully. Forms will be returned if insufficient information is provided and all supporting documentation is not attached. If this documentation is not received it may jeopardise entry into the programme.

CLIENT DETAILS:

Client Name: ______________________ Date of Birth: ______________ Age:_______

Sex: Male/Female Date of Referral:____________________

Address: ____

Home phone no: ______________________Work Phone ___________________________

Moblie Phone No: _________________________________

Name of Parent/Carer/Advocate: __________________________________Age: _______

Address: ____

Home phone no: ______________________Work Phone: ___________________________

Moblie Phone No: _________________________________

Method of communication used: ____

Language spoken at home: _________________________ Interpreter required? □ Yes □ No

Culturally and linguistically diverse background (Country of birth):_____________________

Aboriginal/Torres Strait Islander □ Yes □ No

ELIGIBILITY CRITERIA

The primary disability (please specify)

- ❑ Intellectual
- ❑ Physical or sensory
- ❑ Other

____

REASON FOR REFERRAL:

Please tick one or more boxes:

- ❑ At risk of entering of the Juvenile Justice system or has had a court appearance
- ❑ At risk of becoming homeless/homeless
- ❑ Risk of loss of placement in a day programme, school or employment
- ❑ Ageing Carers (over 55 ATSI or over 65 other)
- ❑ from a CALD/ATSI background.
- ❑ Financial Assistance/Budgeting
- ❑ Living skills and social supports required
- ❑ Isolation
- ❑ Accommodation
- ❑ Domestic assistance
- ❑ Advocacy
- ❑ Health related issues
- ❑ At risk of abuse by others
- ❑ Physical aids/equipment
- ❑ Seeking a day programme option
- ❑ Family breakdown
- ❑ Respite access

Please describe current situation:

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TYPES OF ASSISTANCE OR SERVICES REQUIRED

Please tick one or more boxes

- ❑ Day Options
- ❑ Domestic Assistance
- ❑ Peer Support
- ❑ Respite Care
- ❑ Accommodation support
- ❑ Behaviour Support
- ❑ Support with health needs
- ❑ Other. (Please list)

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HAVE ANY ASSESSMENTS BEEN CONDUCTED? *(Please attach all assessments)*

- ☐ Speech
- ☐ Medical Health Care Plan
- ☐ Occupational Therapy
- ☐ Behaviour Intervention Plan
- ☐ Psychological Assessments
- ☐ Other ___________________________

ARE YOU CURRENTLY RECEIVING ANY SERVICES? YES / NO

If yes please tick and name the provider

- ☐ Day Options: ___________________________
- ☐ Domestic Assistance: ___________________________
- ☐ Peer Support: ___________________________
- ☐ Respite Care: ___________________________
- ☐ Personal care: ___________________________
- ☐ Case Management: ___________________________
- ☐ Other: ___________________________

ARE THERE ANY OTHER ISSUES OR NEEDS THAT NEED TO BE TAKEN INTO CONSIDERATION WHEN ACCESSING THE HOME BY THE CASE MANAGEMENT SERVICE? YES / NO

If yes please describe:

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CONSENT:

A parent or guardian must sign if the client is under 18 years.

Person and / or Guardian are aware and agree to referral being made?

☐ YES ☐ NO

If no, please describe reason:

____

Client/Parent/Guardian's Signature: ___________________________

Client/Parent/Guardian's Name: _______________ Date of Birth: _______________

Relationship to client: _______________ Contact phone no: _______________

PERSON MAKING REFERRAL:

Name: _______________ Contact phone no: _______________

Service and/or organisation: ___________________________

Address: ___________________________

Relationship to client: ___________________________

Signature ___________________________ **Date:** _______________

FOR OFFICE USE ONLY

Case Number:

Person accepted onto the programme? **YES / NO**

If no:

1. **State reason:**

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2. **Referred to:**

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Date: ____________________ **Case Manager:** ______________________

Please send referral to:

Attention: Disability Case Management & Brokerage Support Programme
PO Box 15
AUSTRAL NSW 2179

If you require any assistance to complete this form or have any questions, please contact the programme on ***PH: 9606 9628***