



Y5: YOUTH CASE MANAGEMENT REFERRAL FORM

Introduction:

The Junction Works Youth Case Management service supports young people between the ages of 12-17, and their families, residing in the Liverpool LGA. The primary focus is on young people who are most disadvantaged and/or are at risk of homelessness, experiencing violence or other abuse, living in youth refuges, have drug and alcohol issues, have direct experience of the Juvenile Justice system, are in the care of Community Service, have low levels of school participation, have mental health issues or special needs.

Please take the time to complete the form fully. Forms will be returned if incomplete. Please attach all supporting documentation.

CLIENT DETAILS:

Client Name: _____

Date of Birth: _____ **Age:** _____ **Sex:** Male Female

Telephone number: _____

Address: _____

Aboriginal/Torres Strait Islander Origin Yes No

CALD Yes No

Interpreter required? Yes No
(If yes, Language required: _____)

Country of Birth: _____

Parent/Guardian Details

Name/s of Parent/Guardian/DoCS officer: _____

Address: _____

Telephone number: _____ **Mobile:** _____

Aboriginal/Torres Strait Islander Origin Yes No

CALD Yes No

Interpreter required? Yes No
(If yes, Language required: _____)

Country of Birth: _____

CONSENT:

Person and / or Guardian are:

Aware of referral Yes No **and, gives consent** Yes No

(If either party answered no, please give reason):

Guardian's Name: _____ **DOB:** _____

Relationship: _____ **Contact Phone No.:** _____

Guardian Signature: _____ **Date:** _____

Name of General Practitioner/Psychologist:

Contact Number: _____ **Fax Number:** _____

HAVE ANY ASSESSMENTS BEEN COMPLETED?

- Speech
- Medical
- Other

- Dental
- Psychological

Are they available for file? Yes No
(if no, please obtain copies)

CURRENTLY INVOLVED WITH ANOTHER SERVICE? Yes No

If yes please tick one or more boxes and describe:

- DOCS _____ Ph _____
- Refuge _____ Ph _____
- Peer Support _____ Ph _____
- Respite Care _____ Ph _____
- Group Home _____ Ph _____
- ADHC _____ Ph _____
- Other _____ Ph _____

TYPES OF ASSISTANCE OR SERVICES REQUIRED (Please Describe):

Please tick one or more boxes and describe

- Peer Support _____
- Assistance with accommodation _____
- Behaviour Support _____
- Other _____

ARE THERE ANY OTHER ISSUES OR NEEDS THAT NEED TO BE TAKEN INTO CONSIDERATION WHEN ACCESSING THIS HOME BY THE CARER OR THE SERVICE PROVIDER? Yes No

If yes please describe:

(Attach additional pages if necessary)

PERSON MAKING REFERRAL:

Name: _____

Contact Phone No.: _____ Email: _____

Service and/or organisation: _____

Address: _____

Relationship to client: _____

Signature of person making referral: _____ Date: _____

OFFICE USE ONLY:

ACTION REQUIRED:

Approved? Yes No

If no:

1. Reason:

2. Referred to:

Email signed form to: ycm@thejunctionworks.org

Or fax to: Youth Case Manager

Fax No.: 02 9606 9296