Case Work Referral Form (0-18 years)

Please email this completed form to **strongminds@woodville.org.au**

THIS IS NOT A CRISIS SERVICE. Please phone 000 or Mental Health Access Line 1800 011 511 for emergencies.
This is the form for Strong Minds and Targeted Early Intervention programs. Referrals received after midday Friday will not be processed until the next business day. This referral is not a guarantee of a service being offered.

Details of Child/Young Person (0-18 years)

First Name		Family Name	
Date of Birth		Gender (please tick)	Male ☐ Female ☐ Intersex ☐ Indeterminate ☐
Address			
Phone		Email	
Country of Birth		Cultural Background	
Preferred Language		Interpreter Required (please tick)	☐ Yes ☐ No

Do you identify as Aboriginal or Torres Islander? (please tick) ☐ Yes ☐ No ☐ Wish not to state

Residential Status (please tick) Citizen ☐ Permanent Resident ☐ Asylum Seeker ☐ Refugee ☐ Visa Status

Details of Other Children Requiring Support

Name		Date of Birth	
Name		Date of Birth	
Name		Date of Birth	

Details of Parent/Caregiver of Child/Young Person

First Name		Family Name	
Relationship to Child/Young Person		Gender (please tick)	Male ☐ Female ☐ Intersex ☐ Indeterminate ☐
Address			
Phone		Email	
Date of Birth			
Preferred Language		Interpreter Required (please tick)	☐ Yes ☐ No

Referrer Details (if applicable)

First Name		Family Name	
Position		Organisation	
Phone		Fax Number	
Email		Is the child/young person/family aware of this referral? (please tick)	☐ Yes ☐ No

Description of Presenting Concerns

Please provide as much information as possible (e.g. psychological/emotional/behavioural/physical/social problems, learning difficulties, development issues, play or peer issues, family difficulties, parenting/attachment issues and/or other.

Case Work Referral Form (Continued)

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What other services are working with the child, young person and the family?

What is the child/young person/family's goal/reason for requesting this service?

Is there a mental health diagnosis?

Are there any access issues (please tick) ☐ Mobility ☐ Hearing ☐ Sight ☐ Communication ☐ Other (please specify below)

Are there any current child protection concerns? (please tick) ☐ No ☐ Yes **If yes**, please **phone** the Child Protection Helpline **13 12 11**

Are there any current Domestic Violence concerns? (please tick) ☐ No ☐ Yes **If yes**, please **phone** the Domestic Violence Line **1800 656 463**

Are there any current Family Law Court matters? (please tick) ☐ No ☐ Yes **If yes**, more information may be required.

Risk Assessment

Risk of harm to self (please tick) ☐ No ☐ Yes

Risk of harm to others (please tick) ☐ No ☐ Yes

Current Plan or Intent - please refer to the Mental Health Access Line on 1800 011 511 or 000

Consent

- Client agrees to their information being shared with Woodville Alliance for the purpose of determining eligibility to the program
- Client understands that they will be contacted by the allocated Woodville Alliance Case Worker to arrange an assessment
- Client agrees to their deidentifed data being shared for administrative and project evaluation purposes
- Client understands that they may be contacted by Woodville Alliance or its representative to complete a client experience of care survey

☐ Client understands and agrees to the above referral.

☐ Referrer confirms that consent has been given for this referral to proceed.
Please note that the referral cannot proceed without consent given.

Parent/Guardian has authority to give consent? (please tick) **No** ☐ **Yes** ☐ **Date**

How did you hear about Woodville Alliance? (please tick) ☐ Family/Friends ☐ School ☐ Social Media Facebook/ Twitter/Instagram ☐ Website

☐ Other (please specify)