



REFERRAL FORM

Referring Person Information

Name of School/Agency		
Name of Referring Person		
Role at school/agency		
Contact Details	E:	P:
Date of referral		

Young Person Information

Name of young person		
Address		
Date of Birth and Age	DOB:	Age:
Consented to referral		
Contact Details	E:	P:
Parent/s Name		
Contact Details	E:	P:
Consented to referral		

Referral Information

Reason for referral:		
----------------------	--	--

Other services currently involved:		
------------------------------------	--	--

Referral for which NESAY Program

PROGRAMS	ELIGIBILITY CRITERIA <i>(must meet all elements for referral to be considered)</i>
<input type="checkbox"/> Adolescent Support Program	<ul style="list-style-type: none"> • At risk of entering the Child Protection System <i>(notification has been made or is imminent)</i> • Aged between 12-17 years • Family relationships at risk of breaking down • Risk taking adolescent behaviour • Parenting difficulties
<input type="checkbox"/> Reconnect Program	<ul style="list-style-type: none"> • Aged between 12-18 years • Homelessness or at risk of becoming homeless • Conflict at home • School disengagement
<input type="checkbox"/> Homelessness Programs	<ul style="list-style-type: none"> • Aged between 15-25 years • At risk of or who are homeless • Require support to secure safe sustainable housing options, whilst addressing the barriers that contribute to them being “at risk of homelessness”.
<input type="checkbox"/> HEAL Program	<ul style="list-style-type: none"> • Aged between 15-25 years • 5 week program to develop cooking and independent living skills • Presentations from community service providers
<input type="checkbox"/> L2P Program	<ul style="list-style-type: none"> • Aged 16-20 years • Have a current Learner’s Permit • Not have any health issues that affect safe driving • Be unable to achieve the 120hrs without the L2P program due to challenging financial, family or personal circumstances • Be living in Wangaratta or Mansfield Shire Council areas
<input type="checkbox"/> Leaving Care	<ul style="list-style-type: none"> • Aged between 16-25 years • Transition to post care support • Requires support to transition to post care, whilst working toward independent living.

Record of Consent

Written Consent

The worker has explained to be how and why my information will shared about me with other services. I understand this and I am giving permission for this to be shared. I understand that I have the right to withdraw this consent at anytime.

Client's Signature: _____ Date: ____ / ____ / ____

Guardian signature _____ (where applicable) Date: ____ / ____ / ____

OR

Verbal Consent – **Worker's use ONLY:**

I have discussed with the client how and why their information may be shared with other service providers. I am satisfied that the client understands the proposed uses and disclosures, and has provided their informed consent to these.

Consent obtained or witnessed by:

Name: _____

Position: _____

Signed: _____

Date: ____ / ____ / ____