



ARC – CLIENT REFERRAL FORM

Date of referral: _____ Recorded by: _____

PERSONAL INFORMATION

Full Name: _____ aka: _____

D.O.B: _____ Age: _____ Gender: M F

Cultural Identity: _____ Language spoken at home: _____

Phone No's: (h) _____ (m) _____ (other) _____

Residential address: _____ Postal (if different) _____

Does the Young Person understand the reason for this referral to ARC? Yes No

Young person signature as consent to proceed with referral (mandatory):

YOUNG PERSON'S CURRENT SITUATION

1. Where do they live? (if homeless) _____

2. How long have they lived there? _____

3. How long will they remain at this current address? _____

4. Who else lives there? _____

5. Do they pay rent? _____

6. If yes, how much do they pay? _____

7. Are they on the Dept Housing waiting list? Yes No What is their "T" number? _____

4. Have they been diagnosed with a Mental Health Illness? Yes No Diagnosis: _____

5. Do they use drugs or alcohol? Yes No What do they use? _____ How often? _____

6. Is there a disability service involved e.g. Dept Human Services /ADHC? Yes No

If yes, what is their disability? _____

7. Have they ever been involved in a violent incident? Yes No

Please provide some details?

8. Have they ever intentionally hurt themselves or tried to end their life?

Please provide some details?

9. Have they ever been arrested? Yes No

10. Have they ever had an AVO against them or others? Yes No

Can you please give some details, i.e. who, when, how long, still current?

11. Have they ever been in gaol? Yes No

12. Is Juvenile Justice or Probation and Parole involved? Yes No

13. Is this a Leaving Care (LC) or Aftercare (AC) referral?

14. If this is for Leaving Care, please include the date of the upcoming Leaving Care Conference?

15. If this is a self referral, what/who was your last DoHS/Community Office and Case Worker?

16. Was this young person in OOHC or Kinship Care?

17. What date did this young person leave or will leave the care of the Minister?

18. Have you included a copy of the care order? Yes No (if no, please fax to this office)

19. Have you included a copy of the Leaving Care Plan (LCP)? Yes No (if no, please fax to this office)

Referrer Details

Organisation:

KIDS No: (if DoHS/C referral)

Name of person making this referral:

Job Title:

Contact No:

Fax No:

Email address:

ARC OFFICE USE ONLY

Has a copy of the Care Order been received at this office?

Yes No

Has this referral been added to the Admin Folder?

Yes No

Has this referral been added to the Referral Register?

Yes No