REFERRAL FORM (A)

Please complete all three (3) sections of this form as fully as possible and return to Turning Corners Intake via either;
POST Bravehearts Foundation PO Box 549 Spring Hill Qld 4004
EMAIL scan all pages and email to turningcorners@bravehearts.org.au
FAX (07) 5552 3088

NAME OF YOUNG PERSON BEING REFERRED: _____

SECTION 1 REFERRAL DETAILS

1.1 DETAILS OF REFERRING AGENCY

Referring agency: _____

Agency address: _____

_____

Contact number: _____ Email: _____

1.2 SERVICE REQUESTED BY

Full name of the person referring: _____

Position title of the person referring: _____

_____

Relationship to young person: _____

_____

1.3 FUNDING APPROVAL

Funding for the above work has been approved by:

Name: _____

_____

Position title:

_____

_____

Address for invoice (if different to above):

_____

Signature of person referring: _____Date of referral: ____/____/____

1.4 DETAILS OF OTHER PROFESSIONALS INVOLVED

NOTE: please prepare separate attachment titled *Section 1.4 Referral Form* if more space is required

Other professionals **CURRENTLY** involved		
Name of professional	Role/focus of involvement	Contact number

Other professionals **PREVIOUSLY** involved		
Name of professional	Role/focus of involvement	Contact number

SECTION 2 CLIENT DETAILS

2.1 DETAILS OF YOUNG PERSON BEING REFERRED

First name: _____ Middle name: _____

Surname: _____ Preferred name/s: _____

D.O.B: _____/_____/_____ Gender identity: _____

Current address: _____

_____ Contact number: _____

2.2 CURRENT LIVING ARRANGEMENTS

Parent's home ☐

With relatives ☐

Foster Care ☐

Independent living ☐

Residential school ☐

Other (please specify)

_____

_____

_____

_____

2.2 EDUCATION

NOTE: Please attach any relevant education reports, marked *Section 2.2*

Is the young person currently engaged in education?

☐ No ☐ Yes ☐ Full-time or ☐ Part-time

Name of school/college: _____

Has the young person been identified as having specific learning needs?

☐ No ☐ Yes Please provide brief details: _____

_____

_____

_____

Has the young person been suspended or excluded from school?

☐ No ☐ Yes Please provide brief details: _____

_____

_____

_____

2.3 DRUG AND ALCOHOL USE

Does the young person have a history of drug and alcohol use?

☐ No ☐ Yes → Please provide a brief history of use and treatment (if any):

NOTE: If more space is required, please prepare on separate attachment titled *Section 2.3 History of drug and alcohol use and treatment*

2.4 MENTAL HEALTH CONCERNS

Has the young person been diagnosed with a mental health issue?

☐ No ☐ Yes → Please provide details of diagnosis and therapeutic assistance:

NOTE: If more space is required, please prepare on separate attachment titled *Section 2.4 Mental health details*

Does the young person have a history of significant, patterned behavioural problems (other than those already detailed elsewhere)? If so, please elaborate:

SECTION 3 FAMILY DETAILS [to be completed by primary care giver]

3.1 FAMILY HISTORY

Parent 1: _____ D.O.B _____/_____/_____

Parent 2: _____ D.O.B _____/_____/_____

Relationship status:

☐ Married ☐ De facto

☐ Separated ☐ Divorced

Siblings (list eldest to youngest):

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

People in household (if different from above): _____

_____

3.2 TRAUMA HISTORY

NOTE: If more space is required, please prepare on separate attachment titled *Section 3.2 Trauma history*

Has your child been verbally abused? ☐ No

☐ Yes ☐ Suspected

Please specify: _____

_____

_____

Has your child been physically abused? ☐ No

☐ Yes ☐ Suspected

Please specify: _____

_____

_____

Has your child been sexually assaulted? ☐ No

☐ Yes ☐ Suspected

Please specify: _____

_____

_____

Other stresses or traumas? _____

_____

_____

_____

3.3 SYMPTOM DETAILS

Please indicate (in far left column) the symptoms your child displays and list the number of times per week it is displayed (in far right column):

Tick if applicable	Symptom	Number times per week symptom is displayed
	Anger	
	Anxiety	
	Bed Wetting	
	Acts out sexually	
	Conduct problems	
	Controlling Defecation	
	Has unusual sexual knowledge	
	Day Wetting	
	Defiance	
	Depression	
	Dissociates	
	Drug or alcohol use	
	Homicidal thoughts/actions	
	Hyperactivity	
	Hyper vigilance	
	Masturbates excessively	
	Impaired conscience	
	Isolation	
	Lack of empathy	

	Lack of motivation	
	Lethargy	
	Low impulse control	
	Plays out violent themes	
	Low self-esteem	
	Lying	
	Nightmares	
	Plays out sexual themes	
	Obsesses	
	Over/under eating	
	Phobias	
	Peer problems	
	Sleeplessness	
	Stealing	
	Shy	
	Running Away	
	Difficulty concentrating	
	Tantrums	
	Somatic Symptoms: Headaches/Stomach-aches etc.	

3.4 SIGNATURE [OF LEGAL GUARDIAN]

Signed: _____Date _____/_____/_____

Name: _____

Relationship to child: _____

This section of the referral form [SECTION 3: FAMILY DETAILS] is to be signed by only the legal guardian(s) of listed child seeking individual counselling services. If being signed by a legal guardian other than a parent please list your relationship to the child (e.g. Child Safety Officer) next to your signature.

Information collected on this form is confidential to Turning Corners and Bravehearts (please see Research Consent form and Turning Corners Consent and Conditions of Service for limitations to this confidentiality).