The Courage Project
A BRAVEHEARTS AND MACKAY WOMEN'S SERVICES JOINT INITIATIVE

THE COURAGE PROJECT REFERRAL FORM

TYPE OF REFERRAL: Agency Self QPS Child Safety Other

DATE: ______/_______/_________

When complete, please return this form to intake@bravehearts.org.au

SECTION 1 REFERRAL DETAILS

1.1 DETAILS OF REFERRER

Name of referrer: ______________________________

Referring agency (if applicable): ______________________________

Relationship to client: ______________________________

Contact number: ______________________________

Email: ______________________________

Legal Guardian Consent to referral: Yes No

SECTION 2 CLIENT DETAILS

2.1 DETAILS OF PERSON BEING REFERRED

First name: ______________________________

Surname: ______________________________

Preferred name/s: ______________________________

Gender identity: ______________________________

D.O.B: ______/_______/__________

Cultural identity: ______________________________

Country of birth: ______________________________

Current address: ______________________________

Contact number: ______________________________

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2.2 FAMILY DETAILS

Parent/Carer 1: ______________________________ D.O.B: ____/_____/________

Contact number: ______________________________

Email address: ______________________________

Country of Birth: ______________________________

Language spoken at home: ____________________

Can The Courage Project SMS or leave a voice mail? Yes No

Preferred method of contact: Phone Email

Parent/Carer 2: ______________________________ D.O.B: ____/_____/________

Contact number: ______________________________

Email address: ______________________________

Country of Birth: ______________________________

Language spoken at home: ____________________

Can The Courage Project SMS or leave a voice mail? Yes No

Preferred method of contact: Phone Email

Parent/Carer 1&2 relation status:

Are there any Parenting or Family Law Court orders in place? Yes No

Is an interpreter Required? Yes No

If yes, The Courage Project will request a copy of these Parenting or Family Law Court Orders prior to engaging with a client

Siblings (list eldest to youngest):

Name: ____________________________________ Age: _________

Name: ____________________________________ Age: _________

Name: ____________________________________ Age: _________

Name: ____________________________________ Age: _________

People in household (if different from above): ______________________________________

SECTION 3 REASON FOR REFERRAL

3.1 REASON FOR REFERRAL

Primary Reason for Referral:

Child Sexual Assault | Physical Violence | Sexual Behaviour Problems

Suicidal Ideations | Self-Harm

Additional concerns (tick boxes):

Housing/Homelessness | Financial Concerns | Drug & Alcohol

Neglect | Emotional Abuse

3.2 REFERRAL DETAILS

Please provide detail summary of referral:

SECTION 4 INVOLVEMENT OF AUTHORITIES / COURTS

4.1 AUTHORITY INVOLVEMENT

Has this been reported to:

Police | Child Safety | Both | None

Has the client given a statement to police?

Yes | No

Has the alleged offender(s) been charged?

Yes | No

Is the client currently involved in a court process?

Criminal Just Court　　　　　Family Law Court

Please tick any of the below boxes that also relate to this client:

Youth Justice Involvement　　　　　Child Protection Orders

Mediation is ongoing　　　　　Any DVO or AVO orders in place

Other

FORM COMPLETED BY:

NAME: ____

RELATIONSHIP TO CLIENT: ____

SIGNATURE: ______________________________　　　DATE: ______/______/___________