# AYS CASE MANAGEMENT

## Referral Form • Brisbane

Email to: **HSIntake@atsichsbrisbane.org.au** Phone: **(07) 3240 8900**

| | |
|---|---|
| **Who is referring?** | ○ Self ○ Service Provider ○ Family/Friend |
| **Does the young person consent to referral?** | ○ Yes ○ No |
| **Is the young person between 8-21 years old?** | ○ Yes ○ No |
| **Does the young person live in the Brisbane Region?** | ○ Yes ○ No |
| **Does the young person have low to moderate needs?** *This program does not service young people who are actively offending, transient/homeless, or have complex mental health needs, as they are considered high-needs.* | ○ Yes ○ No |

**If you answered no to any of these questions, please call us to discuss the referral.**

## YOUNG PERSON'S DETAILS:

**Name**

**Does the young person identify as Aboriginal and/or Torres Strait Islander?**

○ Aboriginal ○ Torres Strait Islander ○ Both ○ Neither

**Date of Birth** **Age**

**Gender** ○ Female ○ Male ○ Other/Gender diverse

**Pronouns, e.g. she/her, he/him, they/them**

**Address**

**Phone**

**Living situation** ○ At home ○ Living alone ○ Couch surfing ○ Staying with friends ○ Refuge ○ Supported accommodation/Residential care

**Parent/Guardian Name** **Phone**

**Preferred Contact** ○ Young Person ○ Parent/Guardian ○ Referrer

**Preferred Method** ○ Phone call ○ Text message Other:

ATSICHS BRISBANE


## REFERRAL DETAILS:

**Are there any safety concerns for staff at home/property or immediate risks/alerts?**

**Are any of these issues ocurring/relevant for the young person?**

- ○ Mental health
- ○ Sorry Business
- ○ Legal issues
- ○ Drugs/Alcohol
- ○ Housing
- ○ Physical health
- ○ Parenting/Family
- Other:

**Details**

**What are the main reasons for the referral?**

**Is the young person linked with any other services?** ○ Yes ○ No

**Is the young person subject to Child Safety intervention?** ○ Yes ○ No

## REFERRER DETAILS:

**Name** **Org/Role**

**Phone** **Email**