



AYS CASE MANAGEMENT

Referral Form • Brisbane

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

Date of referral

Who is referring?	<input type="radio"/> Self	<input type="radio"/> Service Provider	<input type="radio"/> Family/Friend
Does the young person consent to referral?	<input type="radio"/> Yes <input type="radio"/> No		
Is the young person between 8-21 years old?	<input type="radio"/> Yes <input type="radio"/> No		
Does the young person live in the Brisbane Region?	<input type="radio"/> Yes <input type="radio"/> No		
Does the young person have low to moderate needs? <i>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.</i>	<input type="radio"/> Yes <input type="radio"/> 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? <input type="radio"/> Aboriginal <input type="radio"/> Torres Strait Islander <input type="radio"/> Both <input type="radio"/> Neither	
Date of Birth	Age
Gender	<input type="radio"/> Female <input type="radio"/> Male <input type="radio"/> Other/Gender diverse
Pronouns, e.g. she/her, he/him, they/them	
Address	
Phone	
Living situation	<input type="radio"/> At home <input type="radio"/> Living alone <input type="radio"/> Couch surfing <input type="radio"/> Staying with friends <input type="radio"/> Refuge <input type="radio"/> Supported accommodation/Residential care

Parent/Guardian Name	Phone
Preferred Contact	<input type="radio"/> Young Person <input type="radio"/> Parent/Guardian <input type="radio"/> Referrer
Preferred Method	<input type="radio"/> Phone call <input type="radio"/> Text message Other:



REFERRAL DETAILS:

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

Are any of these issues occurring/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