Connections WA: Counselling, Psychology, Occupational, Speech and Play Therapy
A: 11/3 Blackburn Drive, (entrance Helmshore Way), Port Kennedy, Perth. 6172
E: admin@connectionswa.com.au
W: connectionswa.com.au
ABN: 34 817 089 184
T: 9524 6491

External Agency Child/Young Person Referral Form

REFERRAL PROCESS:

1. Where possible contact Connections WA on 9524 6491 to discuss potential referral
2. Complete Referral Form and email to info@connections.com.au
3. Connections WA Counsellor/Psychologist will contact the parent/guardian to complete the intake referral
4. An inter-agency meeting will be arranged if necessary / required
5. Parent/guardian and referrer is notified of referral outcome

REFERRAL DETAILS:

AGENCY OR SERVICE:…………………………………………………………………………

CONTACT PERSON: ……………………………..

TELEPHONE: …………………………………………………………………………………

EMAIL: ……………………………………………..

DATE: …………………………………………………………………………………………

NDIS COORDINATOR / PLANNER ORGANISER: …..

CONTACT PERSON: ……………………………………………………………………………

TELEPHONE: …………………………………………………………………………………

EMAIL: ………………………………………………...

DATE: …………………………………………………………………………………………

REFERRER INVOLVEMENT:

No further involvement □
Open case □
Looking for further support □
School referral □
The client is relocating to WA □

Other (detail) □

……
Child/Young person is in the care of the Department for Child Protection & Family Support (CPFS) □
Client/Young person is under a temporary care and protection order of CPFS □
Child Assessment Interview Team still investigating □

Please specify………………………………………………………………………………

Other (detail) ……………………………………………………………………………

…………………………………………………………………………………………

CLIENT DETAILS:

Surname……………………………………………………………

Given Names………………..……………………………………......

Date of Birth…………………….

Age ……………………………...

Gender…...................................

Address……………..……………………………………………………………

Living arrangement and/or visitations with parent(s) or guardian(s) specify name(s)

……………………………………………………………………………………………

…………………………………………………………………………………………....

Clients ‘cultural details …………………………………………..………….…………

Reason for referral ……………………………. ……………………………..………………..

…………………………………………………………………………………………………….

…………………………………………………………………………………………………….

Therapeutic Goals …………………………………………………………………………………

……………………………………………………………………………………………………...

……………………………………………………………………………………………………..

FAMILY DETAILS:

Biological Mother's details (if known):

Surname ………………………………………….

Given Names ……………………………………............

Date of Birth ………………. Age ………………Gender…...............................

Address……………………………………………………………………………....................

Telephone No (H)……………………… (Mob)……………………(Email)…..............................

Biological Father's details (if known):

Surname ………………………………………….

Given Names ……………………………………............

Date of Birth ………………Age…………………Gender…...............................

Address… …………………………………………………………………………….................

Telephone No (H)……………………… (Mob)……………………(Email)…..............................

Are the parents aware of this referral? Yes... □ No… □ If not, details:

…...

OTHER FAMILY MEMBERS:

Name	Date of Birth	Relationship to Client

BACKGROUND DETAILS:

Other services involved (Legal/Justice status):

……………………………………………………………………………………………………..

Charges pending, any charges laid, Court Orders regarding client:

…………………………………………………………………………………………………….

…………………………………………………………………………………………………….

Client or client's family history of domestic violence/family violence:
…………………………………………………………………………………………………….

…………………………………………………………………………………………………….

Client or the client's family history of drug and/or alcohol use:
…………………………………………………………………………………………………….

…………………………………………………………………………………………………….

Client exposure to emotional/physical/psychological abuse or other trauma (eg. car accident, death of Loved one, bullying):
…………………………………………………………………………………………………….

…………………………………………………………………………………………………….

Clients' diagnosis:
…………………………………………………………………………………………………….

…………………………………………………………………………………………………….

Pediatrician……………………………………………………………………………………….

Any medications…………………………………………………………………………………………

Are there any other therapists involved current and past, please provide details?
……………………………………………………………………………………………………

……………………………………………………………………………………………………

Client's current school………………………………………………............

Year…………Teacher/Head of Year. ………………………………………

CURRENT RISK ASSESSMENT**:**

In your opinion, does the client present as a risk to themselves or others?

Harm to Self: □ YES □ NO □ UNSURE
Harm Others: □ YES □ NO □ UNSURE

Please provide as much detail as possible to describe the risk (plan, previous attempt, lethality, intent, means, duration, hopelessness, substance abuse, psych disorder, pain, loss etc.)

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SAFETY PLAN:

Has a safety plan been developed with the client/family in relation to:

- □ Risk of FDV from perpetrator/s
- □ Risk to self from suicide/self-harm
- □ Risk to others from client

Please attach the safety plan

NOTE: IN ORDER FOR THE REFERRAL TO BE PROGRESSED, PLEASE ENSURE THE CONSENT FORM ON FOLLOWING PAGE IS COMPLETED

Parental/Legal Guardian Consent Form

Young Person's details:

Surname ………………………………Given Names …………………………………….

Date of Birth …………………… Age ………………..

This refers to consent to contact the parent/legal guardian, exchange information, leave phone messages and send mails

I, ..…………………………………**Of (address)**…..……………………………..................………

I agree to this referral to Connections WA and give permission for Connections WA Counselling and Psychology Practice to contact me on this number:

……………………………………….. or email: ....

-to discuss this referral and exchange information with the referrer in relation to myself and/or my children when necessary to ensure the safety and well-being of family members.

I understand I can revoke this consent in writing at any time.

SIGNATURE ………………………………………………………..

Print Name……………………………………………………….

DATE ……………………………………………………………..

SIGNATURE ………………………………………………………..

Print Name……………………………………………………….

DATE ……………………………………………………………..

When you sign this document, it will represent an agreement between you and Connections WA.

The Connections WA multidisciplinary team welcome you to the practice and look forward to seeing you soon at our center in Port Kennedy.