**All referrals are received by email to: referrals@picys.org.au**

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| **To be eligible the young person must meet all the criteria below:** |  |  | **Have a number of these other issues:** |  |
| Aged between 16 and 25 (inclusive) | [ ]  |  | Have a diverse sexuality and/or gender | [ ]  |
| Intending to be a long-term resident of WA | [ ]  |  **AND** | Misusing alcohol and/or other drugs | [ ]  |
| Residing within the Perth metro area | [ ]  | Have a mental health illness | [ ]  |
| At risk of homelessness OR transient | [ ]  |  | Exhibit impulsive behaviours | [ ]  |
| Not currently be incarcerated | [ ]  |  | At risk of self-harm | [ ]  |
|  |  |  | Wish to re-engage with family networks | [ ]  |
|  |  |  | Exhibit anxiety or depressive symptoms | [ ]  |
| **Date of Referral** |       |  |  | Domestic violence | [ ]  |

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| **Name of Referrer** |       | **Contact No** |       |
| **Referring Agency** |       | **Email** |       |
| **Reason for Referral - why does the young person wish to be case managed by PICYS? What are some of the goals they wish to achieve?** |
|       |
| **First Name** |       | **Surname** |       |
| **Preferred Name/s** |       | **Alias** |       |
| **Date of Birth** |       | **Country of Birth** |       |
| **Cultural Identity** | Choose an item. | Specify if needed:       |
| **Is an Interpreter Required?** | Yes [ ]  No [ ]  | **Identified Gender** |       | **Pronouns** |       |
| **Email** |       |
| **Current Address** |       |
| **Suburb** |       | **Post Code** |       | **Homeless** | Yes [ ]  No [ ]  |
| **Mobile Phone** |       |  |
| **Medicare Number** |       |
| **Do you receive Centrelink?** | Yes [ ]  No [ ]  | **Do you receive other income?** | Yes [ ]  No [ ]  | **What** |       |
| **Current Living Situation** | Choose an item. | **Trans or gender diverse** | Yes [ ]  No [ ]  | **LGBTIQA+** | Yes [ ]  No [ ]  |

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| **Partner’s Name** |       | **Partner’s Phone** |       |
| **Are you pregnant?** | Yes [ ]  No [ ]  | **If yes, what is your due date?** |       |
| **Do you have children?** | Yes [ ]  No [ ]  | **If yes, please give details; name, age, sex and who cares for the child/ren** |
| **Name** | **Age** | **Sex** | **Carer** |
|       |       |       |       |
|       |       |       |       |
| **Child Protection Order?** | Yes [ ]  No [ ]  | **Which Office?** |       |
| **Have you ever been in prison?** | Yes [ ]  No [ ]  | **If yes, details** |       |
| **Have you ever been in an alcohol or other drug facility?** | Yes [ ]  No [ ]  | **If yes, details** |       |
| **Do you have a disability?** | Yes [ ]  No [ ]  | **If yes, details** |       |
| **Are you on the Department of Housing wait list?** | Yes [ ]  No [ ]  | **When did you apply?** |       |
| **Are you on Department of Housing priority listing?** | Yes [ ]  No [ ]  |  |
| **Are you on any other community housing wait list?** | Yes [ ]  No [ ]  |
| **If yes, what organisation/when did you apply?** |       |
| **If no, do you need assistance applying for community housing/Department of Housing?** | Yes [ ]  No [ ]  |
| **Are you on the “By Name List”** | Yes [ ]  No [ ]  |
| **Have you completed a VISPDAT?** | **If yes, what was you score?** |       |
| **Emergency contact** |       | **Phone/s** |       |
| **Relationship to young person** |       |
| **Next of Kin** |       | **Phone/s** |       |
| **Relationship to young person** |       |
| **Legal guardian** |       | **Phone/s** |       |
| **Relationship to young person** |       |
| **Support Networks** |
| **Agency** | **Person Providing Support Allocated Worker** | **Contact Number** | **Period Engaged** | **Support Provided** |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |
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| **Client’s strengths** |
| Please use this space to tell us a bit about yourself, your likes and the things you are good at.      |
| **Mental Health diagnosis, either self-diagnosis or formally diagnosed** |
|       |
| **Family Dynamic** |
|       |
| **Medical history/Any medical conditions** |
|       |
| **General Practitioner** |       | **Phone** |       |
| **Address** |       |

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| **Past prescribed/non-prescribed medications (dose, frequency)** |
| **Medication** | **Dose** | **Frequency** | **Medication** | **Dose** | **Frequency** |
|       |       |       |       |       |       |
|       |       |       |       |       |       |
|       |       |       |       |       |       |
| **Current prescribed/non-prescribed medications (dose, frequency)** |
| **Medication** | **Dose** | **Frequency** | **Medication** | **Dose** | **Frequency** |
|       |       |       |       |       |       |
|       |       |       |       |       |       |
|       |       |       |       |       |       |
| **Substance Use History and Treatment**  |
| **What** | **How Much** | **Treatment History** |
|       |       |            |
|       |       |            |
|       |       |            |
| **Current substance use , what, how much and current treatment** |
| **What** | **How Much** | **Treatment and History** |
|       |       |       |
|       |       |       |
|       |       |       |
| **Current Risk Factors/Support Areas Required** | **Give Details** |
| **[ ]  Suicidal ideation or behaviour** |       |
| **[ ]  Aggressive behavior/violence** |       |
| **[ ]  Self-harm** |       |
| **[ ]  Self-neglect** |       |
| **[ ]  Alcohol or drug use** |       |
| **[ ]  Debt** |       |
| **[ ]  Vulnerable to abuse/exploitation** |       |
| **[ ]  Risk-taking behaviour** |       |
| **[ ]  Legal issues** |       |
| **[ ]  Other** |       |
| **Has the referral been discussed with the client/parent/guardian?** | Yes [ ]  No [ ]  |
| **Referral signature** |       | **Date** |       |
| **Contact No** |       | **Office** |       |

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| Office Use Only |
| Date Referral Received |       | Date Contacted Referrer |       |
| More Information Needed? | Yes [ ]  No [ ]  | Notify if accommodation becomes available | Yes [ ]  No [ ]  |
| Eligible for Assessment? | Yes [ ]  No [ ]  |  |

**CONSENT TO REFERRAL**

The **PICYS** HouseHold Network Referral form collects information to assist **PICYS** staff to help young people get access to the services they need as quickly as possible.

All information will be treated confidentially and will not be used for any other purposes than what is stated on our confidentiality statement and consent form (signed when the young person arrives for their appointment).

* I am aware that this referral is being made. I understand that I can withdraw from this referral or from the referred service at any time.
* I consent to **PICYS** obtaining relevant information from government and community-based agencies, doctors and other allied health professionals, specifically relevant to my care whilst being a client of **PICYS.**
* I consent to **PICYS** collecting data for the Australian Institute of Health & Welfare.

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|  |  |  |  |  |
| Signed |  | Print Name |  | Date |

If the young person is under 16 years of age, authorisation should (where possible) also be provided by a parent/guardian/carer.

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|  |  |  |  |  |
| Signed |  | Print Name |  | Date |