Agency Referral Form

Youth And Families Association of Pine Rivers Incorporated

Date: _____

Please email: reception@yafa.com.au

Referring Agency Name _____

Referrer's Name _____ Phone _____

Referrer's Email Address _____

Clients Name _____ **Surname** _____

Home Address _____

Suburb _____ Postcode _____

Home Phone _____ Mobile _____

Email Address _____

Date of Birth _____ Sex _____

Family Members needing Counselling:

Parent 1: _____ Parent 2: _____

Children Names	Date of Birth	Children Names	Date of Birth

Has client consented to referral? (Please attach consent form) YES / NO

Has there been Child Safety Department involvement? YES / NO

If Yes, please provide brief details (including current involvement) _____

_____

_____

Agency Referral Form (cont'd)

Are there any Family Court orders in place? YES / NO

If Yes, please provide details _____

_____

_____

Is there domestic violence occurring in the home currently or historically?	Yes / No
Is there any substance addictions ie: drugs, alcohol etc	Yes / No
Has there been any previous suicide attempts, or are there any current suicidal thoughts, or self-harm?	Yes / No
Has there been a diagnosis of Schizophrenia, Eating disorder, Bipolar, Borderline Personality disorder or other Mental Health condition?	Yes / No

If yes, what services are they engaged with if any?

_____

_____

What are the Counselling Needs of the Family? Please circle

Anxiety	School Refusal	Post DV
Depression	Grief & Loss	Relationship Conflict
Gender Issues	ADHD	ASD
Other – please indicate		

_____

_____

Please provide a brief outline of the case: (please attach extra page if more space required)

_____

_____

_____