



CLIENT REFERRAL FORM
After Care Service
Case Managed by Another Service
Provider

DATE: _____

Referring Organisation: _____

Referring person's name: _____

Contact Details: Phone: _____ Mob: _____

Address _____

Email: _____

Details of Young Person

Name: _____

Address: _____

Age: _____ DOB: ____/____/____ Phone: _____ Mobile: _____

Does the young person identify as: Aboriginal TSI Other: _____

Signature of Young Person _____

(The service has been explained and the young person is providing consent to share and record information between the referring agency and Queensland Youth Services)

CRITERIA: (Please tick)

- | | |
|---|---|
| <input type="checkbox"/> Aged 18-20 years | <input type="checkbox"/> Name of Youth Justice Case Worker/Youth Detention Case Worker

_____ |
| <input type="checkbox"/> Exiting care from Child Safety | |
| <input type="checkbox"/> Recently transitioned from Child Safety | |
| <input type="checkbox"/> DOCS Service Centre and name of Child Safety Officer _____ | |
| <input type="checkbox"/> Recently transitioned from a period of detention or remand | |
| <input type="checkbox"/> Name of person completing referral _____ | |
| <input type="checkbox"/> Date Referral was confirmed (within 2 days) _____ | |
| <input type="checkbox"/> Referral form photocopied and put in folder | |