

Reconnect is a service of Queensland Youth Services Inc. and is funded through The Department of Family and Community Services.

CLIENT REFERRAL FORM

DATE: _____

Source of Referral: _____

Person calling: _____ Phone: _____ Mob: _____

Address: _____

Details of Young Person

Name: _____ Relationship to caller: _____

Address: _____

Age: _____ DOB: ___/___/___ Phone: _____ Mobile: _____

School _____ Completing Year _____

Employment /Training _____

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

Basic Issues: (Please tick)

- | | |
|---|--|
| <input type="checkbox"/> Child Protection Services Involved | <input type="checkbox"/> Legal Issues |
| <input type="checkbox"/> Any Child Protection Orders in place | <input type="checkbox"/> Disability |
| <input type="checkbox"/> Financial difficulty | <input type="checkbox"/> Homeless or at risk of homelessness |
| <input type="checkbox"/> Conflict with parents | <input type="checkbox"/> Other services involved (Please list) |
| <input type="checkbox"/> School Issues | _____ |
| <input type="checkbox"/> Mental Health Issues | <input type="checkbox"/> Other: _____ |

Outline of current needs:

- Name of person completing referral _____
- Waiting List Explained (If applicable)
- Referral form photocopied and put in folder
- Inappropriate Referral