



QYFSS Referral Form

Guidelines for referral to the service:

This form is to be used only by referring support staff, who wish to refer clients to assessment and/or support to address concerns in relation to School, AOD, Mental Health, and behaviour issues.

QYFSS will process this referral form and create a file for the client. The assessment team will then be able to provide the right support and advice to the young person.

Confidentiality

Confidentiality is a right for anyone attending counselling at QYFSS. Information disclosed during sessions is strictly confidential. Notes written after each session are kept in a secure location. Support workers may discuss information with their supervisor and peers for the purpose of professional supervision and continuous improvement. Support Workers have a duty of care to break confidentiality if they believe that the person receiving counselling is at risk and/or at risk of harming themselves or others. At times case files can be subpoenaed by the court. In these instances, QYFSS may be obligated to hand over case files. In some instances, support workers are required by law to inform authorities if they have been given information about past, present or future crime(s).

Referral Date

Click or tap to enter a date.

Name of School / Service

Choose an item.

Child/Young Person's details:

Surname

Click or tap here to enter text.

First Name

Click or tap here to enter text.

DOB* DD/MM/YYYY

Click or tap to enter a date.

Contact Number

Click or tap here to enter text.

Gender *

Click or tap

Ethnicity (ATSI/CALD) *

Choose an item.

Address*

Address line 1

Click or tap here to enter text.

Address line 2

Click or tap here to enter text.

City

Click or tap here to enter text.

State/Region

Click or tap here to enter text.

Please return this form to ceo@qyfs.org.au



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Once the assessment team has had a chance to review this form, we will be contacted you and the young person for intake.

*This process normally will take 24-48 hours.

1. **The child or young person is aged between 8 and 21 years***
 Yes No

2. **What age group does the young person fall under?**
 8-12 12-18
 19-21 22-25

3. **The child or young person has a family member or friend being supported by QYFSS**
 Yes No

4. **Does the child or young person have a child safety involvement?**
 Yes No

5. **Education**
 poor numeracy/literacy low academic performance truancy
 Bullying/alienation other: [Click or tap here to enter text.](#)

6. **Personal**
 medical condition disability or disorder substance abuse/misuse
 Mental health poor self-esteem poor social skills
 Poor discipline/behaviour other: [Click or tap here to enter text.](#)

7. **The child or young person resides in the Greater Ipswich region***
 Yes No

8. **The child or young person agrees to participate in the program***
 Yes No

9. **Parent/guardian written consent for their child/young person to participate in the program***
 Yes No

10. **Present Living Arrangement***
 Foster Home Shelter Home (parents) Group Home Other (Specify Below)

[Click or tap here to enter text.](#)



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Parent/Guardian details:

Surname*

Click or tap here to enter text.

First Name*

Click or tap here to enter text.

Contact Number

Click or tap here to enter text.

Email

Click or tap here to enter text.

Referrer details:

Name of Referrer

Click or tap here to enter text.

Phone

Click or tap here to enter text.

Email

Click or tap here to enter text.

Is the Young Person aware of the Referral? Yes No

Previous and/or existing contact with other agencies/organisations (e.g. Department of Child Safety)

Please list any agency/organisation that the child is currently, or has previously been linked with (please include the name of the worker and contact details): *

Click or tap here to enter text.

Please provide a brief history of the family or the child and reason(s) for the referral?

Click or tap here to enter text.



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I have read and I understand the process above. I agree with my young person/s to engage in QYFSS. I will contact QYFSS if I have further questions.

It is helpful for counsellors to discuss relevant information about your child/ren with the school for counselling purposes. This authorization is only valid during agreed work with QYFSS and the young person. This authority will remain in place until you indicate otherwise. Consent can be withdrawn at any time by notifying my QYFSS worker.

I have read and I understand the process above. I give permission for QYFSS to release and obtain information from my child's school.

Information that is exchanged is for the purpose of work as agreed by parent and or young person only. This authorisation is only valid during agreed work with QYFSS. Consent can be withdrawn at any time by notifying my QYFSS worker.

I have read and understand the process above and give permission for QYFSS obtain and release information from/to the following agencies or family members:

Signature/Consent:

Name of Young person*

Signature

Click or tap here to enter text.

Date

Click or tap to enter a date.

Parent 1/ Guardian 1 Name*

Signature

Click or tap here to enter text.

Date*

Click or tap to enter a date.

Parent 2/ Guardian 2 Name*

Signature

Click or tap here to enter text.

Date*

Click or tap to enter a date.

Verbal Consent Given Yes No