Referral Form

Servicing NW Tasmania, King Island, Circular Head and West Coast
Supporting Youth and Families Towards a Better Future

A: 62 Stewart St, Devonport, 7310
P: 03 6423 6635 W: www.yfcc.com.au
Email: reception@yfcc.com.au

Date:……/……/…….

Name_____ D.O.B. _____ Age_____

Address: _____Suburb_____

Phone: _____ Gender: _____

Who is the service for? ☐Self ☐Significant Other

Drug/s of Concern: _____

Treatment delivery setting: ☐Office ☐Home ☐Other (Please specify) _____

Mental Illness: ☐Yes ☐No ☐Unsure (if yes, please specify) _____

Does client have current orders? (E.g. Mental Health, Corrections, Child Safety) ☐Yes ☐No ☐Unsure (if yes, please specify below)

_____

Referring Agency: _____

Name of Worker: _____

Phone:_____ Email:_____

Does client have an active case management plan? ☐No ☐Yes- Contact Person?_____

Comments:_____

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Please feel free to attach any further information regarding this referral

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CONSENT TO RELEASE INFORMATION

I,_____consent to: _____of

_____ releasing information regarding myself to: YFCC.

I understand that this consent will expire 12 months from the date of signing or on the termination of my contact with YFCC whichever occurs first. I understand that I may withdraw this authorisation, in writing, at any time prior to the expiry date, except where action has already been taken on the basis of this authorisation.

Client Signature_____ Worker Signature_____