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: atods@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_______________________________