Drummond Street Services

External Provisional Referral Form

This provisional referral form is for the use of external practitioners in referring clients to drummond street services.

Please ensure that all fields are completed providing as much information as possible. If something is not relevant to a particular client, please mark this appropriately, so that we are aware the question has been asked.

Please do not change the formatting of this template. If you are completing this form by hand, please print clearly.

If the referral is illegible, or if fields are left blank, the form will be returned as we will be unable to proceed.

**Please email through the completed Provisional Referral Form to:** **intake@ds.org.au**

After we have received a completed copy of this form, one of our Intake workers will review this provisional referral to establish whether drummond street services are able to offer suitable supports for your client.

We may seek to contact you prior to contacting the client/family to clarify referral details.

Please be aware this is a provisional referral form. Once the referral review process is complete, you will be informed of the outcome as to whether the referral has been accepted.

Please allow up to 7 business days for the Intake Team to get back to you.

Don’t hesitate to contact us with any questions or to discuss a potential referral:

*Drummond Street Service Intake Team*

*intake@ds.org.au*

*03 9663 6733*

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| **REFERRER DETAILS** |
| **Name:** | Click or tap here to enter text. |
| **Position:** | Click or tap here to enter text. |
| **Agency Name:** | Click or tap here to enter text. |
| **Contact Phone:** | Click or tap here to enter text. |
| **Contact Email:** | Click or tap here to enter text. |
| **Role in working with the client/family currently:** | Click or tap here to enter text. |
| **Will you continue working with the client/family?** [ ] **Yes** [ ] **No****Details:** Click or tap here to enter text. |
| **CLIENT CONTACT FOR REFERRAL** |
| **Name:** | Click or tap here to enter text. |
| **Contact Number:** | Click or tap here to enter text. |
| **Contact Email:** | Click or tap here to enter text. |
| **Can a message be left on the client’s phone?** [ ] **Yes** [ ] **No****Other comments:** *Please be specific if writing a comment, eg. are there safety concerns if a message is left;**or voicemail/SMS only, etc.*Click or tap here to enter text. |
| **Interpreter required?** [ ] **Yes** [ ] **No** **Preferred language or languages (place in order of preference). If it is a specific regional dialect, please specify:** Click or tap here to enter text.**Interpreter gender for cultural reasons:** Click or tap here to enter text. **OR** [ ]  **No Gender Preference** |

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| **CLIENT CONSENT** |
| ***Yes, I (client name)*** Click or tap here to enter text. ***give consent for (name of referrer)*** Click or tap here to enter text. ***to share my/my family’s information with drummond street services for the purpose of a referral to the service.*****Signature Date:** Click or tap to enter a date. **Client Name:** Click or tap here to enter text.[ ]  **Written Consent** [ ] **Verbal Consent**  |
| [ ] ***Yes, I have discussed this referral with my client.*****Signature date:** Click or tap to enter a date. **Referrer’s Name:** Click or tap here to enter text. |
| **CLIENTS BEING REFERRED TO DRUMMOND STREET SERVICES** |
| **Adult Client Names** | **DOB** | **Address** |
| Click or tap here to enter text. | Click or tap to enter a date. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap to enter a date. | Click or tap here to enter text. |
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| Click or tap here to enter text. | Click or tap to enter a date. | Click or tap here to enter text. |
| **Children’s Names** | **DOB** | **Address** | **Relationship to adult client** |
| Click or tap here to enter text. | Click or tap to enter a date. | Click or tap here to enter text. | Click or tap here to enter text. |
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| **REFERRAL DETAILS** |
| **Presenting issues for client/family:** *Describe issues, including onset and duration of concern.* | Click or tap here to enter text. |
| **What support is the client seeking?** | Click or tap here to enter text. |
| **What are you, the referrer, seeking from the referral?***Describe the purpose and aim of the referral, including any specialist support being sought.* | Click or tap here to enter text. |
| **Any other comments or observations helpful for Intake to know about risk issues?***Please be as specific as possible.*Click or tap here to enter text.Suicide ideation: [ ] **Yes** [ ] **No** Details:Click or tap here to enter text.Self harm: [ ] **Yes** [ ] **No** Details: Click or tap here to enter text.Aggressive/unpredictable behaviour: [ ] **Yes** [ ] **No** Details: Click or tap here to enter text. |
| **Is Child Protection involved? Is there a current Child Protection Order?** [ ] **Yes** [ ] **No** [ ] **Yes** [ ] **No****Are there any current parenting orders?** [ ] **Yes** [ ] **No** **Details:** Click or tap here to enter text. |
| **Are there any current Intervention Orders?** [ ] **Yes** [ ] **No** **Details:** Click or tap here to enter text. |

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| **Factors impacting on family health and wellbeing:** | **Historical** | **Current** |
| Adult mental health symptoms | [ ] **Yes** [ ] **No** | [ ] **Yes** [ ] **No** |
| Emotional, behavioural or mental health symptoms in child | [ ] **Yes** [ ] **No** | [ ] **Yes** [ ] **No** |
| Failure to attend school and/or disengagement | [ ] **Yes** [ ] **No** | [ ] **Yes** [ ] **No** |
| Financial Hardship | [ ] **Yes** [ ] **No** | [ ] **Yes** [ ] **No** |
| Frequent family/couple conflict and/or family violence | [ ] **Yes** [ ] **No** | [ ] **Yes** [ ] **No** |
| Homelessness | [ ] **Yes** [ ] **No** | [ ] **Yes** [ ] **No** |
| Interpersonal difficulties in child | [ ] **Yes** [ ] **No** | [ ] **Yes** [ ] **No** |
| Parenting difficulties | [ ] **Yes** [ ] **No** | [ ] **Yes** [ ] **No** |
| Physical health concerns in child | [ ] **Yes** [ ] **No** | [ ] **Yes** [ ] **No** |
| Recent stressful event |  | [ ] **Yes** [ ] **No** |
| Social isolation of family and/or lack of community connections | [ ] **Yes** [ ] **No** | [ ] **Yes** [ ] **No** |
| Substance abuse | [ ] **Yes** [ ] **No** | [ ] **Yes** [ ] **No** |
| Additional risk factors such as violence or abuse by community or systems | [ ] **Yes** [ ] **No** | [ ] **Yes** [ ] **No** |
| **Other Formal Supports Involved** |
| **Agency** | **Contact Name & Position** | **Contact Details**  | **Role with family** |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
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