

CHILD, ADOLESCENT TRAUMA COUNSELLING REFERRAL FORM

Referral Date:	
Person Making Referral	
Name:	
Position:	
Organisation:	
Contact Number:	
Referral is for (eg counselling, group, Protective Behaviours education)	
Parent/Carer Name:	Is aware of/agrees to referral? <input type="checkbox"/>
	Is willing to be contacted directly? <input type="checkbox"/>

Child's or Adolescent's Details	
Name:	
Date of Birth:	Male <input type="checkbox"/> Female <input type="checkbox"/>
Address:	
Parent/carer contact person:	
Home phone:	
Mobile phone:	
Any previous counselling:	
Any diagnosis?	Carer:

Child:		Other:	
Any disability? Child:		Carer:	
Child's school:	Class:	Teacher:	
Siblings + DOB/Age:			
Other family members:			
Relevant others:			
Current Issues/Background			
Out of Home Care:	No <input type="checkbox"/>	Yes <input type="checkbox"/>	
Sexual abuse:	No <input type="checkbox"/>	Yes <input type="checkbox"/>	
Physical abuse:	No <input type="checkbox"/>	Yes <input type="checkbox"/>	
Exposure to domestic/family violence:	No <input type="checkbox"/>	Yes <input type="checkbox"/>	
Neglect:	No <input type="checkbox"/>	Yes <input type="checkbox"/>	
Self harm:	No <input type="checkbox"/>	Yes <input type="checkbox"/>	
Suicidal thoughts/behaviours:	No <input type="checkbox"/>	Yes <input type="checkbox"/>	
Mental health issues:	No <input type="checkbox"/>	Yes <input type="checkbox"/>	
Learning difficulty:	No <input type="checkbox"/>	Yes <input type="checkbox"/>	
Referred to JIRT:	No <input type="checkbox"/>	Yes <input type="checkbox"/>	

JIRT interview completed: __/__/__

Is the child or young person currently involved with any other support services?

Please describe:

Background/Reason for referral

Any other areas of concern

Australian Privacy Principle # 5: Notification of the collection of personal information

I have notified the client regarding the nature of the information disclosed on this form and the client is fully aware of this referral.

Signature of referrer:

Date:/..../.....