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| **Referrer Details** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Referral to:** | Aboriginal Family Led Decision Making  Alcohol and Other Drugs  Bushfire Recovery – Wangaratta  Bushfire Recovery – Wodonga  Cultural Support Planning  Family Violence/Homelessness | | | | | | | | | | | | | | HACC/CHSP  Health Promotion and Chronic Care  Koori Families as First Educators  Koori Maternity Service  Koori Preschool Assistant  Local Justice  Social Emotional Wellbeing – Wangaratta | | | | | | | Social Emotional Wellbeing – Wodonga  Youth Justice | | | | | | | |
| **Referral type:** | Choose an item. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Have you sought permission and consent from the participant/client to discuss their personal information with us?** | | | | | | | | | | **Yes**  **No** | | | | | | | | | | | | | | | | | | | |
| **Date Referral Submitted:** | | | | | | | | | | Click or tap to enter a date. | | | | | | | | **Referrers Name:** | | | | | |  | | | | | |
| **Referrer’s Organisation:** | | | | | | | | | |  | | | | | | | | **Referrers Phone No:** | | | | | |  | | | | | |
| **Program (if internal):** | | | | | | | | | | Choose an item. | | | | | | | | **Role of Referrer:** | | | | | |  | | | | | |
| **Client Details** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name:** | | | |  | | | | | | | | | | | | | | | | | | | | | **D.O.B:** | | |  | |
| **Address:** | | | |  | | | | | | | | | | | | | | | | | | | | | **Gender:** | | | Choose an item. | |
| **Contact Number:** | | | |  | | | | | | | | | | | | | | | | | | | | | **Pronouns:**  (she/they/he) | | | Choose an item. | |
| **Email:** | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| **It is safest to:** | | **Phone  Email  Leave message  Other** | | | | | | | | | | | | | | | | | | **Details:** | | | | | | | | | |
| **Communication:**  (e.g. do they need an advocate, hearing impairment, literacy support etc.) | | **Yes**  **No**  **Unknown** | | | | | | | | | | **Details:** | | | | | | | | | | | | | | | | | |
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| **Disability:**  (Mobility concerns, NDIS funded etc.) | | **Yes**  **No** | | | | | | | | | | **Details:** | | | | | | | | | | | | | | | | | |
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| **MyAgedCare** | | **Yes**  **No** | | | | | | | | | | **Details:** | | | | | | | | | | | | | | | | | |
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| **Emergency contact** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name:** | | |  | | | | | | | | **Contact number:** | | | | |  | | | | | | | **Relationship:** | | | | | Choose an item. | |
| **Other Services Involved** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name:** | | | | | | | **Organisation:** | | | | | | | | | | | | **Service Provided:** | | | | | | | | **Contact Details:** | | |
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| **Cultural Information** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Place of Birth:** | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | City, State, Country | | | | | | | | | | | | | | | | | | | | | |
| **Cultural Identity:** | | | | | | | | Aboriginal | | | | | | | | Torres Strait Islander | | | | | | | | | | Both | | | Neither |
| **Language Spoken:** | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
| **Interpreter required?** | | | | | | | | Yes  No If **yes** please state which language: | | | | | | | | | | | | | | | | | | | | | |
| **Tribe/Mob Identified:** | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
| **Is this person connected to their local Aboriginal Community?** | | | | | | | | Yes  No | | | | | | **Details:** | | | | | | | | | | | | | | | |
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| **Children and Family Support Circle** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name** | | | | | **D.O.B** | | | | | | **Relationship** | | | | | | **Address** | | | | **Cultural Identity** | | | | | | | **Contact Details** | |
|  | | | | |  | | | | | | Choose an item. | | | | | |  | | | |  | | | | | | |  | |
|  | | | | |  | | | | | | Choose an item. | | | | | |  | | | |  | | | | | | |  | |
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|  | | | | |  | | | | | | Choose an item. | | | | | |  | | | |  | | | | | | |  | |
| **Court Orders** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Order** | | | | | | | | | **Date Order Granted** | | | | | | | | **Expiry Date of Order** | | | | | | | | | | | **Not Applicable** | |
| **IVO:** | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | N/A | |
| **Child Protection Order:** | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | N/A | |
| **Family Law:** | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | N/A | |
| **Other legal matters:** | | | | | | **Details:** | | | | | | | | | | | | | | | | | | | | | | N/A | |
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| **Safety Information**  (Please provide details of issues if applicable in comment boxes and attached any MARAM and Safety Plans) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Safety** (e.g. behaviour, worker safety, etc.) | | | | | **Yes**  **No**  **Unknown** | | | | | | | | **Details:** | | | | | | | | | | | | | | | | |
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| **How and when should we contact client?** (e.g. time, day, locations, phone, email or mail) | | | | | | | | | | | | | **Details:** | | | | | | | | | | | | | | | | |
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| **Provide details of the client’s current level of safety:** | | | | | | | | | | | | | **Details:** | | | | | | | | | | | | | | | | |
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| **Has a risk assessment plan been completed such as MARAM?** | | | | | **Yes**  **No**  **Unknown** | | | | | | | | **Details:** | | | | | | | | | | | | | | | | |
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| **Does the client have a safety plan in place and when it was written?** | | | | | **Yes**  **No**  **Unknown** | | | | | | | | **Details:** | | | | | | | | | | | | | | | | |
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| **Provide the client’s protective behaviours:** (what kind of strategies have they put in place? I.e. support networks etc.) | | | | | | | | | | | | | **Details:** | | | | | | | | | | | | | | | | |
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| **Provide details to support us in working with the client:** | | | | | | | | | | | | | **Details:** | | | | | | | | | | | | | | | | |
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| **Support required for housing?** (homeless, living with others etc.) | | | | | **Yes**  **No**  **Unknown** | | | | | | | | **Details:** | | | | | | | | | | | | | | | | |
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| **Identified Mental Health and Wellbeing concerns?** | | | | | **Yes**  **No**  **Unknown** | | | | | | | | **Details:** | | | | | | | | | | | | | | | | |
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| **Alcohol and Other Drug concerns?** | | | | | **Yes**  **No**  **Unknown** | | | | | | | | **Details:** | | | | | | | | | | | | | | | | |
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| **Reason for Referral**  *Please list any co-existing needs or additional information* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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