MacKillop Family Services

WA-F-163 Coolamon Agency Referral Form

Please email all referrals to HSB@mackillop.org.au

Client Details		
Client Name:		
Cultural Background: *(Please provide details)*		
DOB:		
Gender:		
Address:		
Contact Number:		
If under 18:	**Name of Primary Carer:**	
	Relationship to Child/Young Person:	
	DOB:	
	Contact Number:	
Is this child/young person under the care of the Department of Communities?	**Yes** ☐ **No** ☐ *(If yes, please provide details below)*	
	Name of Case Manager:	
	Case Manager Contact Details:	

Referrer Details	
Referrer Name:	
Referrer Email:	
Referrer Contact Number:	
Referrer Organisation:	

Referral Details	
Date of Referral:	
Reason for Referral: *Please describe the harmful, or concerning, sexual behaviours, including information on:* - *When/where* - *Frequency of behaviour* - *Who was involved (relationship to young person, and ages)*	
What steps have been taken to help support the child/young person regarding this behaviour? *E.g. Strategies, services.*	
Is there a current safety plan for the child?	**Yes** ☐ **No** ☐ *(If yes, please attach a copy)*
Has there been any involvement with the Police/Legal/Justice System in relation to	**Yes** ☐ **No** ☐ *(If yes, please provide details)*

the sexual behaviours?	

Some of the other worries for this child are: *(Check all that apply)*

☐ Feeling worried	☐ Suicidal behaviour or suicidal thoughts
☐ Physical health	☐ Hearing voices or seeing things
☐ Not sleeping good	☐ Harmful, or worrying sexual behaviour
☐ Not eating good	☐ Feeling sad, or not interested in doing things
☐ Grog, gunja or other drugs	☐ Trouble focusing and/or remembering things
☐ Trouble with the law	☐ Family trouble, humbug or worry
☐ Gets wild or aggressive	☐ Running off to unsafe places
☐ Grief and loss	☐ Homelessness
☐ Mixed up thoughts	☐ Diagnoses (e.g., Autism, FASD)
☐ Not going to school	*Please specify:*
☐ Self-harm behaviour	

Other concerns, or barriers to accessing service:

Things that help this child/individual feel happy and strong:

Genogram: *(Please attach a copy or insert in space below)*

Other services involved:

What are your hopes/goals for what can be achieved by accessing our service?

Does the child/individual have any allergies or special dietary requirements? *(Sometimes our service may provide snacks)*	**Yes** ☐ **No** ☐ *(If yes, please provide details below)*	
Emergency Contact *(Who can we contact if there is an emergency or if we can't get a hold of the client and are worried for their safety?)*	**Name:**	
	Relationship to Client:	
	Contact Number:	