|  |  |
| --- | --- |
| Date of Referral |  |

|  |  |  |
| --- | --- | --- |
| Have you heard of Dardi Munwurro prior to now? |  Y |  N |
| If yes, have you attended any of our programs or services? |  Y |  N |

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| --- |
| YOUNG PERSON DETAILS |
| **First name** |  | **Last name** |  |
| **Young Person’s preferred pronouns**  | he/him she/her they/them They prefer not to say  |
| **Nickname** |  |
| **Date of birth** |  | **Age** |  |
| **Address** |  |
| **Postcode** |  | **Mobile****number** |  |
| **Mob (If known)** |  |
| **Email** |  |

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| --- |
| GUARDIAN/EMERGENCY CONTACT DETAILS |
| **First name** |  | **Last name** |  |
| **Address** |  |
| **Postcode** |  | **Mobile****number** |  |
| **Email** |  |

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| REFERRAL DETAILS |
| **Source of referral** |  |
| **Contact details**1. **Name**
2. **Mobile**
3. **Email**
 |  |

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| INVOLVEMENT WITH OTHER SERVICES |
| **Is the young person involved with Youth Justice?** | Yes | No |
| **Comments** |  |

|  |  |  |
| --- | --- | --- |
| **A client of child protection?** | Yes | No |
| **Comments** |  |
|  |  |  |
| **Involved with Alcohol and Other Drugs program?** | Yes | No |
| **Comments** |  |  |

|  |  |  |
| --- | --- | --- |
| **Involved with Mental Health?**  | **Yes** | **No** |
| **Comments** |  |  |
| **Involved with other services?** | **Yes** | **No** |
| **Name and contacts of other services the young person is engaging in** |  |

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| --- |
| LIVING SITUATION (CROSS ONE) |
| **Lives with family** |  | **Lives independently** |  |
| **Lives in some type of out of home care** |  | **Does not have fixed address**  |  |
| **Comments** |  |

|  |
| --- |
| EDUCATION |
| **Highest completed level of education** |  | **Currently attending school** | Yes | No |
| **School name** |  |

|  |
| --- |
| EMPLOYMENT |
| **Currently employed?**  | Yes | No | **Length of employment (weeks)** |  |
| **Number of hours worked in past month** |  | **If not currently employed, have you ever had a job?** | Yes | No |

|  |
| --- |
| INTEREST AND HOBBIES |
|  |

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| --- |
| HEALTH |
| **Is the young person experiencing any illness at the moment?** | **Yes** | **No** |
| **If yes:*** **Type of illness**
* **How long you have had this illness**
* **What you have been told about how long it might last**
* **What treatment you are seeking**
 |  |  |

|  |
| --- |
| PERMISSION TO CONTACT YOUNG PERSON – YES / NO |
|   **Referrer name Referrer signature Date Allocated**  |

|  |
| --- |
| CONTACTS |
| **(ph) 03 8456 3044****(e)** **youthservices@dardimunwurro.com.au****ABBY KAY:****(m) 0456 370 713****ZAC LOVETT:****(m) 0417 695 145****TOM VUCENIK:****(m) 0448 886 520** |