**The Junction Works**
Community, Youth & Children Services
T: 02 8777 0500
E: cycteam@thejunctionworks.org

# CYC REFERRAL FORM

**Please email the completed Referral Form to cycteam@thejunctionworks.org**

**Date of referral: ___/___/____**

The Junction Works Community, Youth and Children's Team is a service, which provides support to children, young people, and individuals. To be eligible for the service the client must reside or attend our services in the following LGAs **Liverpool, Campbelltown, Canterbury – Bankstown or Fairfield.**

Please note that The Junction Works Community, Youth and Children's Services is not an emergency, on-call, or after hours service. Our CYC services are a short-mid term support service **(12 sessions – up to 6 months)** with the primary focus of supporting clients achieve their identified goals and needs. The Community, Youth, and Children's team work with clients who are in need of support services, have experienced abuse, experiencing trauma, educational and employment support, mental health, social and emotional support, behavioural issues, advocacy and empowerment.

Please take the time to fill out this form as best you can and attach any supporting documents (if necessary). Please be aware that as this is a program funded by the

Depar tment of Communities & Justice, your information will be kept confidential and securely stored on the Data Exchange.

## Contact Details

**Address:** Wattle Grove Community Centre,
8 Village Way Wattle Grove NSW 2173

**Phone:** (02) 8777 0500

**Email:** cycteam@thejunctionworks.org

**Website:** https://thejunctionworks.org

## Service required (please tick one):

- ☐ Counselling
- ☐ Case Management
- ☐ Information and Referral
- ☐ Mentoring or Peer Support

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## Client Details

**Title (*please tick*): Mr☐Mrs☐Miss☐Ms☐**

| | |
|---|---|
| **Full Name:** | |
| **Date of Birth:** | |
| **Gender:** | |
| **Address:** | |
| **Contact Number:** | |
| **Email Address:** | |
| **Country of birth:** | |
| **Language spoken:** | |

**Does the client identify as Aboriginal, Torres Strait Islander or CALD? (Please specify):**

**Homelessness Status (*please tick*):** No☐Yes☐At Risk☐

**Household Composition (*please tick*):** Single☐Sole Parent☐Couple☐Couple with☐ Dependents☐Group (related adults☐/ Group (unrelated adults☐ Homeless or No Household ☐

## Parent/Guardian Details (if client is under 16yrs)

**Title *(please circle)*: Mr☐Mrs☐Miss☐Ms☐**

| | |
|---|---|
| **Full Name:** | |
| **Date of Birth:** | |
| **Gender:** | |
| **Address:** | |
| **Contact Number:** | |
| **Email Address:** | |
| **Country of Birth:** | |
| **Language spoken:** | |
| **Aboriginal, TSI or CALD?:** | |

**Interpreter Required:** ***(Please outline)***

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## School Details (Children/Youth only)

| | |
|---|---|
| **School:** | |
| **Year:** | |
| **School Phone:** | |
| **School Email address:** | |
| **School Contact Person (if applicable):** | |

## Other Agencies Involved

**Include Psychologists and GP If known.**

| Name of Agency | Name | Contact Number |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

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## Referral Information

*Please tick all appropriate:*

- ☐ Homeless
- ☐ At risk of homelessness
- ☐ Educational Issues: (circle appropriate answer)
  - ☐ History of truancy
  - ☐ Suspension
  - ☐ Disengagement
- ☐ History of abuse
- ☐ At risk of abuse
- ☐ Substance Abuse
- ☐ Family Breakdown/DV
- ☐ Behavioural Issues
- ☐ Disability (please outline the disability) _____
- ☐ Health Issues: (please outline the health issue) _____
- ☐ Mental Health (please outline the mental health condition) _____
- ☐ Self-Harm
- ☐ Emotional Issues
- ☐ Legal Issues/JJ Involvement
- ☐ Financial Support: Employment/Centrelink
- ☐ Community/Social Support needed

***Please note, the referral will be assessed and the outcome advised.***

**Has a Psychological Assessment been completed?** YES☐ NO☐(*please tick*)

**Is the client currently engaged in a program of treatment aimed at reducing drug or alcohol use?** YES☐NO☐*please tick*– if YES please provide more information

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**Has the client ever been hospitalised for the purpose of psychiatric assessment and/or treatment?** YES☐NO☐ *please tick*- if YES please provide more information below)

**Does/Has the client ever had any court orders in place?** YES☐NO☐ *please tick* - If YES please provide more information below)

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## Presenting Issues/Reasons for referral

Please provide all information in detail:

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## CLIENT RISK ASSESSMENT PROFILE

| | |
|---|---|
| **Record of previous deliberate self-harm** | ☐ **YES** ☐ **NO** ☐ **Insufficient Information** |
| **Currently threatening suicide and/or self-harm** | ☐ **YES** ☐ **NO** ☐ **Insufficient Information** |
| **Previous or current incidents of actual or threatened violence** | ☐ **YES** ☐ **NO** ☐ **Insufficient Information** |
| **Previous or current threat to use weapons** | ☐ **YES** ☐ **NO** ☐ **Insufficient Information** |
| **Threatened or actual aggression (physical or verbal) towards others** | ☐ **YES** ☐ **NO** ☐ **Insufficient Information** |
| **Misuse of drugs (prescribed or illegal)** | ☐ **YES** ☐ **NO** ☐ **Insufficient Information** |
| **Excessive use of alcohol** | ☐ **YES** ☐ **NO** ☐ **Insufficient Information** |
| **Evidence of self-neglect (such as poor hygiene)** | ☐ **YES** ☐ **NO** ☐ **Insufficient Information** |
| **Evidence of risk through abuse/exploitation from others** | ☐ **YES** ☐ **NO** ☐ **Insufficient Information** |
| **Sexually inappropriate behaviour** | ☐ **YES** ☐ **NO** ☐ **Insufficient Information** |
| **Record of previous property damage** | ☐ **YES** ☐ **NO** ☐ **Insufficient Information** |
| **Previous or current record of gambling** | ☐ **YES** ☐ **NO** ☐ **Insufficient Information** |
| **Previous record of crime/s committed** | ☐ **YES** ☐ **NO** ☐ **Insufficient Information** |
| **Evidence of current neglect/violence/emotional abuse** | ☐ **YES** ☐ **NO** ☐ **Insufficient Information** |

**Please comment on 'Yes' and 'Insufficient Information' answers. Consider recency, frequency and severity. Please outline the actions in response to previous or current risks identified**

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## CLIENT RISK ASSESSMENT PROFILE (cont'd)

**Please comment on 'Yes' and 'Insufficient Information' answers. Consider recency, frequency and severity. Please outline the actions in response to previous or current risks identified**

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## CLIENT RISK ASSESSMENT PROFILE (cont'd)

### DOMESTIC VIOLENCE

| | |
|---|---|
| **Physical** | ☐ **YES** ☐ **NO** ☐ **Insufficient Information** |
| **Verbal** | ☐ **YES** ☐ **NO** ☐ **nsufficient Information** |
| **Financial** | ☐ **YES** ☐ **NO** ☐ **nsufficient Information** |
| **Sexual** | ☐ **YES** ☐ **NO** ☐ **nsufficient Information** |
| **Social** | ☐ **YES** ☐ **NO** ☐ **nsufficient Information** |
| **Emotional** | ☐ **YES** ☐ **NO** ☐ **nsufficient Information** |
| **Spiritual** | ☐ **YES** ☐ **NO** ☐ **nsufficient Information** |
| **Elder/Child** | ☐ **YES** ☐ **NO** ☐ **nsufficient Information** |
| **Tech-based** | ☐ **YES** ☐ **NO** ☐ **nsufficient Information** |

**Please comment on 'Yes' and 'Insufficient Information' answers. Consider recency, frequency and severity. Please outline the actions in response to previous or current risks identified**

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## Consent

Is the client aware of this referral? YES☐ NO☐ *Please tick*

Is the client willing to engage with our service? YES☐ NO☐ *Please Tick*

Are the Parent(s)/Guardian aware of the Referral? YES☐ NO☐ *Please Tick*

Does the parent(s)/Guardian Give Consent? YES☐ NO☐ *Please Tick*

Name of Parent(s)/Guardian (if different from person listed on page 2)

**Name:**

**Contact Number:**

**Email:**

## Person Making Referral

**Name:**

**Contact:**

**Email:**

**Service/Organisation:**

**Relationship to client:**

**Signature:** **Date:**

## OFFICE USE ONLY

**Date referral received:**

**Date referrer emailed advising of referral outcome:**