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 Department of Communities & Justice, your information will be kept confidential and

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'S PERSONAL DETAILS			
Title:	**Mr ☐ Mrs ☐ Ms ☐ Miss ☐**	**Date of Birth:**	
Family Name:		**Given Name:**	
Address:			
Suburb:		**Postcode:**	
Contact Number:		**Homelessness Status: ☐ No ☐ Yes ☐ At Risk**	
Email:		**Sex: F ☐ M ☐**	
Country of Birth:		**Main Language Spoken at Home:**	

Do you identify as Aboriginal or Torres Strait Islander?
☐ No ☐ Yes – Aboriginal ☐ Yes - Torres Strait Islander

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

Highest level of education/qualification: **☐ Pre-Primary Education ☐ Primary Education** **☐ Secondary Education ☐ Certificate Level** **☐ Advanced diploma or diploma level** **☐ Bachelor degree level** **☐ Graduate diploma or graduate certificate level** **☐ Postgraduate degree level ☐ Other Education**	**Employment Status:** **☐ Paid work full-time ☐ Paid work part-time** **☐ Unpaid work (includes volunteering)** **☐ Not working and not looking for work** **☐ Unemployed (not working but looking for work)** **☐ Studying full-time ☐ Studying part-time** **☐ Parenting ☐ Caring**
Main source of income: **☐ Nil income ☐ Employee Salary/Wages** **☐ Self Employed (Unincorporated business income)** **☐ Government Payments/Pensions/Allowances** **☐ Other income including superannuation and investments** **☐ Not stated/inadequately described**	**Year and month of first arrival in Australia**
Visa type: **☐ Humanitarian ☐ Family** **☐ Skilled ☐ Other**	**Ancestry**
Is client a carer: ☐ Yes ☐ No	**NDIS eligibility:** **☐ NDIS in-progress access request** **☐ NDIS eligible** **☐ NDIS ineligible**

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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?:

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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 circle)

Is the client currently engaged in a program of treatment aimed at reducing drug or alcohol use? YES / NO (please circle – if YES please provide more information below)

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

Does/Has the client ever had any court orders in place? YES/NO (please circle - 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** ☐ **Insufficient Information**
Financial	☐ **YES** ☐ **NO** ☐ **Insufficient Information**
Sexual	☐ **YES** ☐ **NO** ☐ **Insufficient Information**
Social	☐ **YES** ☐ **NO** ☐ **Insufficient Information**
Emotional	☐ **YES** ☐ **NO** ☐ **Insufficient Information**
Spiritual	☐ **YES** ☐ **NO** ☐ **Insufficient Information**
Elder/Child	☐ **YES** ☐ **NO** ☐ **Insufficient Information**
Tech-based	☐ **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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Consent

Is the client aware of this referral? YES / NO (Please Circle)

Is the client willing to engage with our service? YES / NO (Please Circle)

Are the Parent(s)/Guardian aware of the Referral? YES / NO (Please Circle)

Does the parent(s)/Guardian Give Consent? YES / NO (Please Circle)

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: