# CYC Referral Form

## TJW # F-CYP018

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

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

| About |
|---|
| 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, Camden, Wollondilly or Fairfield.**<br><br>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.<br><br>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 | |
|---|---|
| Contact Number | (02) 8777 0500 |
| Email Address: | cycteam@thejunctionworks.org |
| Website: | https://thejunctionworks.org |

| Service Required – please tick all that apply |
|---|
| ☐ Counselling – **Liverpool, Campbelltown and Camden only** |
| ☐ Case Management |
| ☐ Information and Referral |
| ☐ Mentoring or Peer Support |

| Personal Information | | | |
|---|---|---|---|
| **Gender:** | | **Date of Birth:** | |
| **Family Name:** | | **Given Name:** | |
| **Address:** | | | |
| **Suburb:** | | **Postcode:** | |
| **Contact Number:** | | **Email:** | |
| **Ancestry (culture you primarily identify with):** | | **Disability:** ☐ **Yes** ☐ **No** | |
| **Country of Birth:** | | **Main Language Spoken at Home:** | |
| **Do you identify as Aboriginal or Torres Strait Islander?** ☐ **No** ☐ **Yes – Aboriginal** ☐ **Yes - Torres Strait Islander** | | | |
| **Emergency Contact 1 – must be a parent/guardian if client is under 16** | | | |
| **Name:** | | **Relationship:** | |
| **Phone Number:** | | **Email Address:** | |
| **Address:** | | **Suburb and Postcode:** | |
| **Emergency Contact 2:** | | | |
| **Name:** | | **Relationship:** | |
| **Phone Number:** | | **Email Address:** | |
| **Address:** | | **Suburb and Postcode:** | |
| **School Details:** | | | |
| **School:** | | **Year:** | |
| **School Phone Number:** | | **School Email Address:** | |
| **School Contact Person:** | | | |

| Other Agencies Involved – Include Psychologists and GP if known | | |
|---|---|---|
| **Name of Agency** | **Full Name of Practitioner** | **Contact number/Email** |
| | | |
| | | |
| | | |

| Referral Information<br>*Please tick all appropriate:* | | |
|---|---|---|
| ☐ Homeless | ☐ At risk of homelessness | ☐ Family Breakdown/DV |
| ☐ History of Abuse | ☐ At risk of abuse | ☐ Substance Abuse |
| ☐ Behavioural Issues | ☐ Emotional Issues | ☐ Self-Harm |
| ☐ Legal Issues/JJ Involvement | ☐ Financial Support: Employment/Centrelink | ☐ Community/Social Support needed |
| ☐ Educational Issues (tick all that apply):<br>☐ History of truancy<br>☐ Suspension<br>☐ Disengagement | | |
| ☐ Disability (please outline the disability): | | |
| ☐ Health Issues (please outline the health issue): | | |
| ☐ Mental Health Condition (please outline mental health condition): | | |

| Psychological Assessment, Treatment & Court History | |
|---|---|
| Has a Psychological Assessment been completed? | ☐ Yes ☐ No |
| Is the client currently engaging in a program of treatment aimed at reducing drug and alcohol use? If Yes, please elaborate. | ☐ Yes ☐ No |

| | |
|---|---|
| Has the client ever been hospitalised for the purpose of psychiatric assessment and/or treatment? If Yes, please elaborate | ☐ Yes ☐ No |
| Does/Has the client ever had any court orders in place? If Yes, please elaborate. | ☐ Yes ☐ No |

| **Presenting Issues/Reasons for referral**<br><br>*Please provide all information in detail* |
| --- |
| |

| 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 on the next page. Consider recency, frequency and severity. Please outline the actions in response to previous or current risks identified.*

## Client Risk Assessment Profile – Additional Information

| Client Risk Assessment Profile – 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 below. Consider recency, frequency and severity. Please outline the actions in response to previous or current risks identified.*

| Client Risk Assessment Profile – Domestic Violence – Additional Information |
|---|
| |

| Consent | |
|---|---|
| Is the client aware of this referral? | ☐ Yes ☐ No |
| Is the client willing to engage with our service? | ☐ Yes ☐ No |
| Are the Parent(s)/Guardian aware of the Referral? | ☐ Yes ☐ No |
| Does the parent(s)/Guardian Give Consent? | ☐ Yes ☐ No |

| Person Making Referral | | | |
|---|---|---|---|
| Full Name: | | | |
| Contact Number: | | | |
| Email Address: | | | |
| Service/Organisation | | | |
| Relationship to Client: | | | |
| Signature: | | Date | |

| Office Use Only | |
|---|---|
| Date referral received | |
| Date referrer emailed advising of referral outcome | |

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