C.A.T.C.H

Child & Adult, Therapy, Counselling & Healing

nexus Primary Health
living well in your community

Referral form

Child & Young Persons' Details

Service Required: Please select

Client Name: **Client ID:** **Gender:**

Address: **Town & Postcode:**

Birthdate: **Mobile:** **Email:**

Cultural Identity:

Proposed Funding for service:

Referral Details

Name: **Profession:** **Contact Phone Number/Email**

	Yes	No	Unknown
Is family aware of Referral?			
Has consent been given? *Provide consent form			
Previous involvement with Child Protection?			
Is Child Protection involved with family now?			
If Yes, which family member and at what stage:			
Has the family been affected by Family Violence			
Is there current contact with the perpetrator?			
Has a Risk Assessment been completed?			

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Additional – Children & Young Persons' Details

Name:	**Birthdate:**	**Gender:**
Address:		
Relationship:	**ATSI** Please select	**In Home?** Please select

Name:	**Birthdate:**	**Gender:**
Address:		
Relationship:	**ATSI** Please select	**In Home?** Please select

Name:	**Birthdate:**	**Gender:**
Address:		
Relationship:	**ATSI** Please select	**In Home?** Please select

Name:	**Birthdate:**	**Gender:**
Address:		
Relationship:	**ATSI** Please select	**In Home?** Please select

Name:	**Birthdate:**	**Gender:**
Address:		
Relationship:	**ATSI** Please select	**In Home?** Please select

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Parents, Guardians, Care Givers

Name:	**Birthdate:**	**Gender:**
Address:		
Mobile/Phone No's:		
Relationship:	**ATSI** Please select	**In Home?** Please select

Name:	**Birthdate:**	**Gender:**
Address:		
Mobile/Phone No's:		
Relationship:	**ATSI** Please select	**In Home?** Please select

Carer/Parent's capacity to commit to services for self and children

Reason for Referral (presenting issues, client needs)

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What are the client goals?

What services will you (referrer) continue to provide?

Service Name	Current Service	Contact Person	Phone/Mobile	Contact Date	Consent to Contact
					Please select
					Please select
					Please select
					Please select
					Please select

Safety Assessment Alerts

Are there any concerns for the children's wellbeing and safety. Court orders?

Offices: Broadford, Seymour, Wallan, Kinglake and Community Outreach

Please return referral to: intake@nexusprimaryhealth.org.au

Phone: 1300 77 33 52