OFFICE USE ONLY

KURINDA ADOLESCENT SERVICE – INITIAL REFERRAL FORM

REFERRAL INFORMATION		
Person's Name:	DOB: / /	Age:
Person's Current Address:	Gender: ☐Male ☐Female ☐N/A	
	Person's Phone Number:	
Type of Accommodation (Current): ☐Family Home ☐Refuge ☐Friend ☐Relative ☐Hospital ☐Other: *(please specify)*	Mental Health Diagnoses:	
How long will person be at current address?		
What accommodation is arranged after they leave current address?	Medical Conditions/Concerns:	
Referring Person's Name:	Agency and/or Relationship:	
Referring Person's Address:	Referring Person's Phone:	
	Referring Person's Email:	

SUMMARY OF REASON FOR REFERRAL

ENTRY CRITERIA	
Has a diagnosis been made formally? When? By whom?	
Any history of psychosis? ☐Yes ☐No	*Please describe:*
History of suicidal ideation or behaviour? ☐Attempted ☐Ideation	*Please describe (include frequency):*
History of self-harm? ☐Yes ☐No	*Please describe (method, frequency, most recent):*
History of violent behaviour? ☐Yes ☐No	☐Physical ☐Verbal ☐Towards self ☐Towards Others ☐Towards Objects
	Please describe:

ENTRY CRITERIA CONTINUED	
Is there a history of use of any drugs or alcohol (including abuse of prescription drugs)? ☐Yes ☐No	*What substance/s?* *How long did they use?* *Frequency of use?* *Are they currently substance free? For how long?*
Any developmental disabilities? If so, please list.	
Support Needs: Please tick	☐Living Skills ☐Social Skills ☐Medication Monitoring ☐Safe Environment ☐Transport Skills ☐Money Management Skills ☐Healthy Eating/Nutrition ☐Enrolment in Education ☐Finding Work/Vocational Training ☐Emotional Self-Care ☐Personal Hygiene ☐Recreational Opportunities ☐Building Self-Esteem ☐Advocacy ☐Education Around Drugs and/or Alcohol ☐Education Around Sexual Health/Hygiene ☐Other:
Details of School/TAFE/Uni and/or Work	
What other services are involved in supporting the young person? Please list service, contact person, type of support	
What type of social network does the young person have? (friends, family, other)	
Does the young person take any medication? Please list names and dosages	
Has the young person agreed to the referral being made?	
How did you find out about Kurinda?	

Please email this completed form to info.kurinda@aftercare.com.au
or post to Aftercare: PO Box 83 Seven Hills NSW 2147