Safe Youth, Safe Communities

Inala, Ipswich and Logan

Providing a culturally appropriate service for young people, their families and the community

Known as the Pasifika LIPI program

REFERRAL FORM

Date of Referral: _____

Name of Referral Service: _____ ***Ph No***: _____

Name of Case Worker: _____ ***Email Address:*** _____

Name of Client _____ ***Previous Client:*** ☐ **Yes** ☐ **No**

Name(s) of Caregivers: _____

Age of Client: _____***(Yrs)***_____***(Mths)*** ***Date of Birth***: _____

Residing Address: _____

Phone Contact: (H)_____***(M)***_____***(W)***_____

Culture/Ethnicity:

☐ Anglo-Australian ☐ Aboriginal ☐ Torres Strait Is ☐ Samoan ☐ Tongan ☐ South Sea Isl

☐ Vietnamese ☐ Maori ☐ Aust/South Sea Islander ☐ Other_____

Caregivers Relationship:

☐ Natural Parent ☐ Step Parent ☐ Foster Care Parent ☐ Residual.Care _____

☐ Other_____

School/Vocational program: _____

Presenting Issue:

☐ Family Conflict ☐ Relationship breakdown ☐ Abuse of YP ☐ Accommodation ☐ School Issues

☐ Domestic Violence ☐ Juvenile Justice issues ☐ Advocacy ☐ Practical Support ☐ Truancy

☐ Mental Health ☐ Substance abuse – YP ☐ Substance Abuse – Parent/Guardian

12 Sittella Street Inala
P.O. Box 141
Inala 4077

Phone 07 3372 2655
Fax 07 3372 2710
Email: inez@iys.org.au

***Expected Requirements of the Service*:**

_____.
_____
_____

***Level of Urgency for client to access Pasifika LIPI services, Please tick appropriate box*:**

☐ Extreme ☐ Medium ☐ Not Urgent/can wait

***Is the young person at risk of being violent? If so, give details/examples*:**

_____.
_____
_____
_____

Has the child been diagnosed with any of the following? Please tick.

☐	ADHD	☐	Dyslexia	☐	Alcohol Foetus Syndrome
☐	Epilepsy	☐	Aspergers	☐	Fragile
☐	Hepatitis	☐	Autism	☐	PTSD – Post Traumatic Stress Disorder
☐	Depression	☐	Asthma	☐	Other: _____

Is the child on any prescribed medication?

_____

Daily Dosage: _____

Doctor's Details: _____

***Behavioural Identifiers, Please circle any appropriate*:**

☐	Patient	☐	Impatient	☐	Introverted	☐	Extroverted
☐	Anxious	☐	Calm				

***Physical Identifiers, Please tick those appropriate*:**

☐	Eczema	☐	Acne	☐	Nail Biter	☐	Grinding Teeth
☐	Constipation	☐	Diarrhea	☐	Self-harmer	☐	Obesity
☐	Anorexia	☐	Other: _____				

Please attach any relevant information or assessments including Medical or Education based.

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***Family Background: provide names, relationship, DOB's, living arrangements etc*:**

Mum:_____

Dad:_____

***Numbere of siblings, order of siblings and gender*:**

_____
_____
_____
_____

***Provide Diagram of immediate family*:**

Example/Scenario of aggressive behaviour – include identified coping skills of client::

_____
_____
_____
_____
_____
_____
_____
_____
_____

Any other information:

_____
_____
_____

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