INALA RECONNECT
REFERRAL FORM
PHONE: 3372 2655 FAX: 3372 2710
Contact via these numbers to make a referral.

DATE OF REFERRAL: / / 2015

** Required Fields*
YOUNG PERSON'S DETAILS*
Name:_____ Date of Birth: / / Age:
Address: _____
Contact No_____
Cultural Identity: _____
Is the Young Person aware of the referral: YES/NO
Does Reconnect have permission from young person to speak with parents: YES/NO

PARENT/GUARDIAN'S DETAILS*
Name/s_____
_____
Address: _____
Contact No _____

CURRENT SITUATION*

Left parent's home for less that one week	yes / no
Left parent's home for between one week and 12 weeks	yes / no
Immediate threat of homelessness	yes / no

BRIEF DESCRIPTION OF CURRENT CIRCUMSTANCES*:

CONCERNS:

ASSESSMENT OF URGENCY* NOT URGENT / MODERATE / IMMEDIATE

ARE ANY OTHER AGENCIES CURRENTLY INVOLVED WITH THIS YOUNG PERSON OR THEIR FAMILY?* Please name below.

_____
_____
_____

OTHER INFORMATION

_____
_____

Please fill in:

REFERRING AGENCY DETAILS*
Contact person/s _____

Phone: _____Mobile _____E-mail___
_____
Best times to contact over the next few days are: _____
What service are you seeking and what would you consider a positive outcome at this point:
_____
_____
_____
_____
_____

Client must be homeless or at risk of homelessness & not under care of the Dept of Child Safety*

Attempts at Contact form

OFFICE USE ONLY:

Date referral received: ____/____/_____ Time: _____ Method:
_____

Reconnect worker who received the referral:
_____

Reconnect MUST attempt to contact the Young Person or family member within 24 hours of receiving a referral.

Attempts to contact:

Date:___/___/_____ Time: _____ Person: _____ Outcome: _____

Date:___/___/_____ Time: _____ Person: _____ Outcome: _____

Date:____/___/_____ Time: _____ Person: _____ Outcome: _____