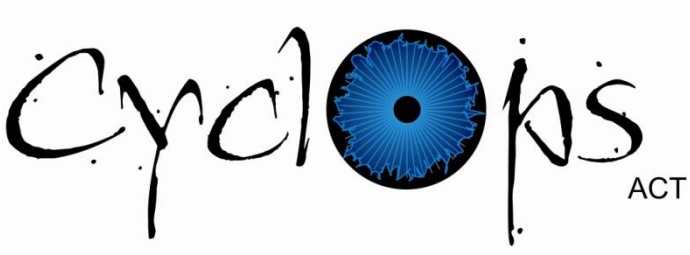

Referral Form

Date: _____

Intake Details:

Referred From:
_____

Agency and Role: _____

Phone: _____

Consent to Share: (Please obtain before sending- referral can not be considered without consent)

Written Consent: Yes/No

Young Carers Name: _____ Signature: _____

Workers Name: _____ Signature: _____

Date: ____/_____/_____

Young Carer Details

Name _____

Address :_____

DOB: ___/____/____ Age: _____ Gender : _____

Phone: Home _____ Mobile _____

Parents/Guardians Names : _____

Email: _____ Preferred Method of Contact _____

Family Background Information (strictly confidential)

Ethnicity: ATSI / NESB – Please specify : _____

Language/s spoken at home: _____

Name/s and age/s of siblings :_____

Information about the young carer and their caring role within the home:

_____

_____

_____

*How can CYCLOPSACT provide Support? Please circle: Case Management/ Casual Support/ SARIS

Other relevant information:_____

_____

_____

Is the Young Carer accessing any other services? Yes/No.

If yes, please provide details:

_____

_____

Is there a current case manager? Yes/No. If yes, please provide details:

Name: _____ Agency: _____ Contact: _____

_____

_____

CYCLOPSACT
PO BOX 287
Civic Square
ACT 2608
62322488

***Case Management**:	Weekly, fortnightly or 3 weekly one on one support visits.
Duration:	14 weeks addressing goals and then review.
Casual Support:	Monthly contact/support as required.
Duration:	Ongoing until needs/circumstances change.
SARIS:	Social and Recreational, Information Support. – Invitations to School Holiday Programs, events and activites.
Duration:	Ongoing until participant reaches 25.