**Referral Form**

**Intake Details**

|  |  |
| --- | --- |
| **Referral Date:** |  |
| **Referring Agency:** |  |
| **Referring Persons Name** |  |
| **Referring Persons Contact Details:** |  |
| **Phone:** |  |
| **Email:** |  |

**Consent to Share Please obtain before sending. Referral cannot be considered without consent**

|  |  |
| --- | --- |
| **Was consent from young carer obtained to send this referral?** | ☐  No ☐  Yes |
| **If Young Person is under the age of 16 years, consent also needs to be obtained from Parent/Guardian** | |
| **Was consent obtained from Parent/Guardian?** | ☐  No ☐  Yes |

**Young Persons Details**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Young Carers Name:** | |  | | | | |
| **Date of Birth** |  | **Age:** |  | **Gender:** |  | |
| **Address:** | |  | | | | |
| **Phone Number:** | |  | | | | |
| **Mobile Phone:** | |  | | | | |
| **Email Address** | |  | | | | |
| **Preferred Method of Contact** | |  | | | | |
| **Language Spoken at Home** | |  | | **CALD** | |  |

**Young Carers Parent/Guardian Details:** (Required if young carer under 16 years)

|  |  |
| --- | --- |
| **Parent/Guardian Name:** |  |
| **Relationship to Young Carer** |  |
| **Phone Number:** |  |
| **Email Address** |  |

**Reason for referral**

|  |  |
| --- | --- |
| **What type of assistance is the young carer seeking?** | |
|  | |
| **Is there any information you think we should know about the young carer that would help support this referral and the young carer’s current situation?** | |
|  | |
| **Is there a current Case Manager?** | ☐  No ☐  Yes |
| **If yes, please provide details:** | Name:  Agency:  Contact: |

|  |
| --- |
| **Please send completed referral form to:**  Anglicare CYCLOPS ACT  [cyclops@anglicare.com.au](mailto:cyclops@anglicare.com.au)  Phone: 02 6232 2488 |