**Referral Form**

**Intake Details**

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| --- | --- |
| **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**

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| --- | --- |
| **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)

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

**Reason for referral**

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| **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: |

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| --- |
| **Please send completed referral form to:** Anglicare CYCLOPS ACTcyclops@anglicare.com.auPhone: 02 6232 2488 |