



Referral Form – Schools

Questions about completing this form? Telephone (03) 9389 8900

Please complete this form on screen, print it out and either:

- fax it to (03) 9277 7871
OR

- post it to 4 Gardiner St, Brunswick VIC 3056

Please note:

- You **MUST** have the consent of the person you are referring before sending this form to Foundation House.
- You can use this form to refer multiple family members – see ‘Referral of family members’ section.
- Please complete as much information on this form as you can.
- A Foundation House worker will contact you within 5 working days after receipt of this form to discuss the referral.

Referrer

DATE REFERRAL MADE (dd/mm/yyyy)		REFERRING SCHOOL	
TEACHER/SWC NAME			
STREET ADDRESS			
SUBURB		STATE	POSTCODE
EMAIL			
TELEPHONE	MOBILE	FAX	

Consent

Does the person being referred consent to the referral?	<input type="checkbox"/> YES
Does the person being referred consent to being contacted directly by Foundation House?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If the person being referred is under 18 years of age, does their parent/guardian consent to the referral?	<input type="checkbox"/> YES <input type="checkbox"/> NO

Person being referred

FAMILY NAME		GIVEN NAME/S	
DATE OF BIRTH (dd/mm/yyyy) – please estimate if exact date not known		GENDER <input type="checkbox"/> Female <input type="checkbox"/> Male	
STREET ADDRESS			
SUBURB		STATE	POSTCODE
EMAIL			
TELEPHONE		MOBILE	
COUNTRY OF ORIGIN		ETHNICITY	
PREFERRED LANGUAGE	INTERPRETER REQUIRED? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, GENDER PREFERENCE FOR INTERPRETER? <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> No preference	
IF THE PERSON ATTENDS SCHOOL, SCHOOL NAME?			
DATE OF ARRIVAL IN AUSTRALIA (dd/mm/yyyy)		VISA STATUS (if known) <input type="checkbox"/> Permanent Resident <input type="checkbox"/> Other _____	

Referral of family members (attach additional pages if necessary)

Please note:

- You MUST have the consent from the family member/s you are referring before sending this form to Foundation House.
- A parent/guardian can consent on behalf of their child/ren.

FAMILY NAME	GIVEN NAME/S
DATE OF BIRTH (dd/mm/yyyy) – please estimate if exact date not known	RELATIONSHIP WITH THE PERSON BEING REFERRED (eg spouse, child, sibling)
DOES THE PERSON CONSENT TO THE REFERRAL? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF THE PERSON ATTENDS SCHOOL, SCHOOL NAME?
FAMILY NAME	GIVEN NAME/S
DATE OF BIRTH (dd/mm/yyyy) – please estimate if exact date not known	RELATIONSHIP WITH THE PERSON BEING REFERRED (eg spouse, child, sibling)
DOES THE PERSON CONSENT TO THE REFERRAL? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF THE PERSON ATTENDS SCHOOL, SCHOOL NAME?
FAMILY NAME	GIVEN NAME/S
DATE OF BIRTH (dd/mm/yyyy) – please estimate if exact date not known	RELATIONSHIP WITH THE PERSON BEING REFERRED (eg spouse, child, sibling)
DOES THE PERSON CONSENT TO THE REFERRAL? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF THE PERSON ATTENDS SCHOOL, SCHOOL NAME?
FAMILY NAME	GIVEN NAME/S
DATE OF BIRTH (dd/mm/yyyy) – please estimate if exact date not known	RELATIONSHIP WITH THE PERSON BEING REFERRED (eg spouse, child, sibling)
DOES THE PERSON CONSENT TO THE REFERRAL? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF THE PERSON ATTENDS SCHOOL, SCHOOL NAME?
FAMILY NAME	GIVEN NAME/S
DATE OF BIRTH (dd/mm/yyyy) – please estimate if exact date not known	RELATIONSHIP WITH THE PERSON BEING REFERRED (eg spouse, child, sibling)
DOES THE PERSON CONSENT TO THE REFERRAL? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF THE PERSON ATTENDS SCHOOL, SCHOOL NAME?
FAMILY NAME	GIVEN NAME/S
DATE OF BIRTH (dd/mm/yyyy) – please estimate if exact date not known	RELATIONSHIP WITH THE PERSON BEING REFERRED (eg spouse, child, sibling)
DOES THE PERSON CONSENT TO THE REFERRAL? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF THE PERSON ATTENDS SCHOOL, SCHOOL NAME?
FAMILY NAME	GIVEN NAME/S
DATE OF BIRTH (dd/mm/yyyy) – please estimate if exact date not known	RELATIONSHIP WITH THE PERSON BEING REFERRED (eg spouse, child, sibling)
DOES THE PERSON CONSENT TO THE REFERRAL? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF THE PERSON ATTENDS SCHOOL, SCHOOL NAME?

Please note: all following questions are about the main person being referred (not family members)

Referral indicators for torture and other traumatic events

HAS THE PERSON BEING REFERRED (tick/click on those which apply):

- disclosed experience of torture or other traumatic events with or without prompting?
- disclosed injury/ies or pain which is/are the result of torture, sexual assault or other form of violence?

TORTURE AND TRAUMA EXPERIENCE (attach additional pages if necessary) A possible question to ask about torture and trauma: "Some people have had bad things happen to themselves and their families. Has anything happened to you or your family that is affecting the way you are feeling now?"

OBSERVATIONS: Tick/click on those which apply – no questions are required, you may observe these or the person may disclose them spontaneously.

- | | |
|--|---|
| <input type="checkbox"/> Crying a lot | <input type="checkbox"/> Sleep problems (too much or too little) |
| <input type="checkbox"/> Intense/persistent emotional distress | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Persistent lack of expression of positive emotions | <input type="checkbox"/> Re-enactment of a traumatic event in play |
| <input type="checkbox"/> Aggressive behaviour or persistent anger | <input type="checkbox"/> Lots of worries |
| <input type="checkbox"/> Fears of going out or other fears | <input type="checkbox"/> Out of control behaviour |
| <input type="checkbox"/> Severe social withdrawal or appears uncommunicative | <input type="checkbox"/> Bed-wetting |
| <input type="checkbox"/> Overreacting to noises in environment | <input type="checkbox"/> Frequent tantrums |
| <input type="checkbox"/> Peculiar appearance, behaviour or speech | <input type="checkbox"/> Not wanting to go to school or infrequent attendance |
| <input type="checkbox"/> Risk taking behaviour | <input type="checkbox"/> Persistent headaches or other aches |
| <input type="checkbox"/> Alcohol or substance abuse | <input type="checkbox"/> Failure to thrive |
| <input type="checkbox"/> Expresses threat to harm self or others | <input type="checkbox"/> Very clingy behaviour |

OTHER COMMENTS ABOUT REASON FOR REFERRAL (attach additional pages if necessary)

OTHER AGENCY INVOLVEMENT NOT PREVIOUSLY MENTIONED

AGENCY	CONTACT PERSON	TELEPHONE

COMMENTS:



Foundation House provides a statewide Schools Support Program. For information, professional learning opportunities for teachers, and resources visit <http://www.foundationhouse.org.au/schools-support/>