Second Chances Referral Form

Date:	**Phone:**
Organisation:	**Email:**
Position:	**Referrer's Name**

CHILD/CLIENT'S DETAILS	
Name of child or young person:	**DOB:**
Address:	**Phone:**
Email:	**School or educational institution:**
Cultural identity:	**Gender:**
Does this child identify as Aboriginal/Torres Strait Islander?	**Interpreter Required?**
Legal Concerns?	**Financial Hardship?**

PARENT OR GUARDIAN'S DETAILS	
Name of primary carer:	**Relationship to child/young person:**
Phone number:	**DOB:**
Cultural identity:	**Is English a second language?**
Interpreter required?	**Is this person aware of the referral?**
Family residential situation:	☐ **Motel/emergency accommodation** ☐ **Short term rental** ☐ **Long term rental** ☐ **Other (please specify)**

Goals for Referral

- ☐ Better school engagement
- ☐ Improved emotional well-being
- ☐ Community protection
- ☐ Practical support
- ☐ Goal setting
- ☐ Advocacy
- ☐ Other (please specify):

Current Supports

Please list formal and informal supports involved

Organisation/relationship	Contact person	Frequency

Safety & Risk Considerations

Challenges & Barriers Associated with the Client

Impact of the Justice System on the Client

Other Relevant Information

Please e-mail the referral to** familysupportteam@secondchances.org.au **or call 08 8272 0323 for any referral related enquiries.