

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**
- email to referrals@foundationhouse.org.au **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.

COVID-19 update

Due to the current COVID-19 restrictions we are encouraging non face to face modes of contact. What is the person being referred’s preferred mode of contact at this time?

- Phone call
 Text message
 Video conferencing platform (Zoom/Web X/Skype)
 Other (Please specify)

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? YES

Does the person being referred consent to being contacted directly by Foundation House? YES NO

If the person being referred is under 18 years of age, does their parent/guardian consent to the referral? YES 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 <input type="checkbox"/> Prefer to self-describe: _____	
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
GENDER PREFERENCE FOR FOUNDATION HOUSE WORKER? <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> No preference	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>