CABL
WELLBEING AND SUPPORT HUB

EXTERNAL REFERRAL FORM

REFERRAL SOURCE			
Referral date:			
Organisation/Agency Name			Self-Referral ☐
Staff Name		Position	
Contact Number		Email	
Has the person provided consent for the referral?	Yes ☐ No ☐		
Is the client connected or have they been referred to any other support service? Yes ☐ No ☐ *Please specify;*			
Agency:	**Worker's name:**	**Contact number:**	

CLIENT INFORMATION		
First name:	Last name:	
Preferred name:	Gender:	Age:
Date of Birth:	Contact Number:	
Do you identify as: ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither		
Country of birth:	Interpreter required: ☐Yes ☐No If Yes - Language:	
Residency Status:		
If referral is for 2 parents/carers, please provide name of second below		
First name:	Last name:	
Preferred name:	Gender:	Age:
Date of Birth:	Contact Number:	
Do you identify as: ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither		
Country of birth:	Interpreter required: ☐Yes ☐No If Yes - Language:	
Residency Status:		
Primary contact:		
Address:		
Email address:		

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Household composition: ☐ Single (person living alone) ☐ Sole Parent with dependant(s) ☐ Couple ☐ Couple with dependant(s) ☐ Group (related adults) ☐ Group **Housing Status** ☐ Homeless/No Household ☐ Not stated or inadequately described
Preferred method of contact: ☐ Phone ☐ Email ☐ Mobile
Can a voicemail message be left on mobile: ☐Yes ☐No Are there immediate safety concerns: ☐Yes ☐No

FAMILY STATUS					
NO DEPENDENT CHILDREN ☐					
Is there **current** DCJ involvement? ☐Yes ☐No Detail: Is there **previous** DCJ involvement? ☐Yes ☐No Detail:					
Name	*DOB*	*Age*	*Disability*	*School/Childcare or Employment*	*Aboriginal/Torres Strait Islander?*
			☐ YES ☐ NO		☐ YES ☐ NO
			☐ YES ☐ NO		☐ YES ☐ NO
			☐ YES ☐ NO		☐ YES ☐ NO
			☐ YES ☐ NO		☐ YES ☐ NO

If you ticked yes to a disability for any family member please identify type of disability:	Details: ☐ Intellectual/learning ☐ Psychiatric ☐ Sensory/speech ☐ Physical/diverse ☐ Developmental ☐ Other:

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FINANCIAL	
Main source of Income:	☐ Nil Income ☐ Employee Salary / Wages ☐ Other Income Incl Super & Investments ☐ Self-employed ☐ Government payments / pensions / allowances ☐ Not stated / Inadequately described
Income Frequency	☐ Weekly ☐ Fortnightly ☐ Monthly ☐ Annually
NDIS Eligibility	☐ NDIS in Progress access request ☐ NDIS eligible ☐ NDIS ineligible

Has this person/family accessed CABL (previously, Burwood Community Welfare Services) before?
☐Yes ☐No

LIVING CONDITIONS	
Is anyone in the family under an AVO? ☐Yes ☐No	Details:
Are there any court order? ☐Yes ☐No	Details:

Where does the person/family live?

☐ Home w family/ guardian	☐ Staying with friends	☐ Other; specify:
☐ Rental property w children	☐ Refuge	
☐ Shared accommodation	☐ Homeless	

FACTORS RELATING TO REFERRAL
(Tick where applicable/known)

☐ Suicide Attempts / Self harm	☐ Mental health	☐ Pregnancy
☐ Cultural issues	☐ Domestic Violence	☐ Financial
☐ Identity issues	☐ Social Isolation	☐ Education/school Attendance
☐ Grief & Loss	☐ Accommodation / at risk of homelessness	☐ LGBTQI+
☐ Drug & Alcohol	☐ Language/literacy Problems	☐ Bullying
☐ Living Skills	☐ Parenting support	☐ Other
☐ Relationship difficulties	☐ Health Issues	

☐ Employment

Please provide further comments to the above ticked points:

STRENGTHS *(Tick where applicable/known)*		
☐ Stable family environment	☐ Secure relationships/ attachments	
☐ Readiness for change	☐ Healthy coping strategies	☐ Economic security
☐ Community Connection	☐ Strong support network	☐ Communication and social skills
☐ Spiritual and/or religious identity	☐ Strong cultural identity and pride	☐ Access to education/services

Please provide further information:

OTHER *Please provide any other information about the person/family that is relevant to referral.*