**OpenSpace**

Open Space aims to strengthen and promote the safety and wellbeing of young people.

Please send referrals to [OpenSpace@communicare.org.au](mailto:OpenSpace@communicare.org.au)

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Referral Information:** | | | | | | | | | | |
| Service location:  Rockingham office | | | | Service required:  Individual Counselling  Youth Worker | | | | | | |
| Referral Date: | | | | Has the client consented to this referral? | | | | | | |
| Referring Agency: | | | | Referred by: | | | | | | |
| Referrers Contact Number: | | | | Referrers Email: | | | | | | |
| Is the client receiving a service through Communicare?  No  Yes, please specify: | | | | | | | | | | |
|  | | | | | | | | | | |
| **Client Details: (Individual)** | | | | | | | | | | |
| Client Name: | | | | | | | | | | |
| Date of Birth: | | | | | | | | | | |
| Gender: | | | | | | | | | | |
| Home Address: | | | | | | | | | | |
| Contact Information (15+ years old) | | | | Safe | Preferred | | Between the hours/days of: | | | |
| Mobile Number: | | | |  |  | |  | | | |
| Email Address: | | | |  |  | |  | | | |
| Home Phone: | | | |  |  | |  | | | |
| Can we say we are from Communicare/OpenSpace when calling?  Yes  No | | | | | | | | | | |
| Cultural identity:  ATSI  CaLD, please specify: | | | | | | | | | | |
| Disability: Please specify diagnosis:  Diagnosed mental health  Physical  Diagnosed intellectual disability | | | | | | | | | | |
|  | | | | | | | | | | |
| **Parent/Carer/Guardian Details:** | | | | | | | | | | |
| Client Name: | | | | | | | | | | |
| Date of Birth: | | | | | | | | | | |
| Gender: | | | | | | | | | | |
| Home Address: | | | | | | | | | | |
| Contact Information | | | | Safe | Preferred | Between the hours/days of: | | | | |
| Mobile Number: | | | |  |  |  | | | | |
| Email Address: | | | |  |  |  | | | | |
| Home Phone: | | | |  |  |  | | | | |
| Can we say we are from Communicare/OpenSpace when calling?  Yes  No | | | | | | | | | | |
| Cultural identity:  ATSI  CaLD, please specify: | | | | | | | | | | |
| Disability: Please specify diagnosis:  Diagnosed mental health  Physical  Diagnosed intellectual disability | | | | | | | | | | |
| **Children: (if applicable)** | | | | | | | | | | |
| Surname | Forename | D.O.B | | Gender | | | | Cultural Identity:  ATSI/CALD/Other | | Diagnosed Disabilities |
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| **Reason for Referral: (Please briefly describe the reason for referral)** | | | | | | | | | | |
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| **History:** | | | | | | | | | | |
| Financial Stressors/Hardship | | | Unemployment | | | | | | Family and Domestic Violence | |
| Family court / Legal Matters | | | Mental Health Issues | | | | | | Suicidal Ideations / Self Harm | |
| Cultural Issues / Racism | | | Alcohol or Drug Use | | | | | | Physical Health Issues | |
| Other, Please Specify: | | | | | | | | | | |
|  | | | | | | | | | | |
| **Other Services:** | | | | | | | | | | |
| Please indicate any additional services that family are currently accessing: | | | | | | | | | | |
|  | | | | | | | | | | |
| **Risk Concerns:** | | | | | | | | | | |
| Are you aware of any potential risks this family may pose on a worker’s safety or to themselves? | | | | | | | | | | |
| **Additional information:** | | | | | | | | | | |
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