Zone Youth Space
Corner Gilmore Ave and Darius Drive Kwinana, 6167 | PO Box 21, Kwinana WA 6966
Hours Mon-Fri 9am-5pm | **Telephone** 08 9236 4556
youth@Kwinana.wa.gov.au | **www.kwinana.wa.gov.au**

City of Kwinana

Kwinana Youth Services

REFERRAL FORM

Kwinana Youth Services offers:

- Support for young people 12-18 years
- intensive case management to young people who live, work, attend school or have a connection to Kwinana.
- Advocacy
- Advice and information
- Referrals to additional supports
- Engaging young people and connecting to community

Kwinana Youth Services is a voluntary service. If the Young Person does not give consent to receiving services or engaging with our case managers, we respect their right to refuse service. Please send referrals and queries through to youth@kwinana.wa.gov.au and a member of Kwinana Youth Services will contact the young person directly. Alternatively you can contact the service on 08 236 4550.

Client Information

First name

Last name

Gender | Pronouns

Date of birth

Phone

Email

Is their a preference to work with a female or male worker ☐ No ☐ Yes - Male ☐ Yes - Female

Has client consented to the referral being made? ☐ Yes ☐ No

Have parents been notified? ☐ Yes ☐ No

Cultural Status

☐ Aboriginal and/or Torres Strait Islander

☐ CaLD *Please specify*

☐ Non- Indigenous

Address *Where you reside the most*

Street

Suburb

Postcode

☐ Currently no fixed address

Clients current circumstances

What would the young person like support with?

☐ Mental health	☐ Disability	☐ Alcohol and other Drugs
☐ Connection to community	☐ Housing/homelessness	☐ Truancy
☐ Other		

Please elaborate on above ticked boxes	
Any back-ground information? *(e.g. family dynamics, current living conditions)*	
What are their hobbies and interests?	
Any areas of concern/ safety concerns? *(Behaviors and risks to staff/client, legal concerns, VRO's etc)*	
Any additional information? *(What services are involved, what services have been involved in the past)*	

Your referral will be triaged and allocated to a Kwinana Youth Services case-manager within 2 working days. The case-manager will make contact with you to advise the referral has been received.

Emergency Contact *Person we can contact in an emergency*

Name	
Number	
Relationship to client	

Referrer details

Date _____ Referrer _____

Organisation / Service	
Phone	
Email	

Would you like to be contacted about the outcome of the Referral ? ☐ Yes ☐ No

Does client consent to information being shared with referrer? *Sign here* _____