Program Referral Form

Please ensure that all information is current to the best of your knowledge. This will assist us to review if our services are best suited to the requirements and needs of the individual.

Section 1: Program Referal Information

Which program are you referring child/(ren)too?

☐ Buddies Day (8-13yrs) ☐ Sense Youth Mentoring (14-17yrs) ☐ Soccer Stars (8-13yrs)

Section 2: Referrer Information

Conference / Organisation Name

Referrer Name

Address Suburb Post Code

Phone / Mobile Email

How long has the young person been associated with your Conference/Organisation?

What is your relationship with the young person? (Case Worker)

Are you able to support referral / initial engagement if needed? ☐ Yes ☐ No

Will there be ongoing contact with the young person? ☐ Yes ☐ No

Are you aware of the young person currently accessing other services? (This will not exclude their involvement)

Section 3: Parent / Legal Guardian Details

Parent / Guardian Full Name

Relationship (Mother, Father, Grandparent)

Address Suburb Post Code

Phone Home Phone Work Phone Home

Email

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Section 4: Child Information

How many children in the immediate family are being referred?

Is the child/(ren) of Aboriginal or Torres Strait Islander origin? ☐ Yes ☐ No

Are the child/(ren) from a culturally and/or linguistically diverse background? ☐ Yes ☐ No

Please provide a brief history of the family or the child/(ren) and reason(s) for the referral? (Please provide a separate sheet if required)

Childs's Full Name	Please Provide details of any relevant information	Date of Birth	Gender

Section 5: Sense Youth Mentee Information (Only)

Please comment on your assessment of the young persons' needs

How do you think a mentor could support the young person?

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Section 6: Referrer Acknowledgement

I, _____ in my capacity as _____ acknowledge that I have spoken to the Parent / Caregiver of and have outlined the nature and requirements of the St Vincent de Paul Society Queensland's Youth Program and they have consented to be contacted by Society Representative.

Is the child(ren) aware they have been referred ☐ Yes ☐ No

I confirm that to my knowledge the above information is a true and accurate reflection of the needs of child/(ren's)

I endorse this referral and consent to being contacted by the St Vincent de Paul Society Queensland's should further information be required.

Please return this form to:

Daniel Ingledew

daniel.ingledew@svdpqld.org.au

0409 836 237

Privacy Statement

St Vincent de Paul Society Queensland collects the information you provide on this form for the primary purpose of obtaining appropriate medical treatment for you if required. We may also use the personal information you provide to contact you, to contact your emergency contact in the event of an emergency, to respond to your enquiries and to ensure your well-being on the camp. If you do not provide the information requested on this form, we may not be able to do these things.
We may share your personal information with other St Vincent de Paul Societies, caterers, hospital staff or other medical providers and with third parties who provide us with professional or technology services, including some that are based overseas. For more information about how we deal with your personal and sensitive information please refer to our privacy policy on our website http://www.vinnies.org.au/page/Privacy/State_Policies/Privacy_Policy_in_QLD/

St Vincent de Paul Society Authorising Signature

Date