

Before completing a written professional referral to The Orange Door please consider if a phone referral would be more suitable: **Call 1800 271 157 to make a phone referral.**

**Access to The Orange Door is not dependant on a service user providing the information requested in this form*

**Please fill in as much information as possible, leaving spaces where the information is not relevant or is not known*

Date of Referral: ___/___/_____

1. Confidentiality and Consent	
Does the referrer consent to their identity being disclosed as the person who made the referral? Yes <input type="checkbox"/> No <input type="checkbox"/>	
The Orange Door prefers to be open with individuals and families regarding their support needs. Wherever possible, referrers should discuss making a referral with the individual or family.	
Has confidentiality and duty of care been discussed with the individual/family? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Has the client provided consent for a referral to be made to The Orange Door? Yes <input type="checkbox"/> No <input type="checkbox"/>	
In accordance with the Privacy Data Protection Act 2014 (PDP) The Orange Door has a responsibility to protect your personal information. The Orange Door takes reasonable steps to make sure that your personal information is protected from misuse, loss, and unauthorized access, modification or disclosure.	
2. Referrer Details	
Name of Referrer:	
Agency / Role:	
Address:	
Email:	
Mobile:	Landline:
Referral Type: Family Violence <input type="checkbox"/> Child Wellbeing <input type="checkbox"/> Both <input type="checkbox"/> Unsure <input type="checkbox"/>	
Do you have significant wellbeing concerns for any of the children? Yes <input type="checkbox"/> No <input type="checkbox"/> Prefer not to Say <input type="checkbox"/> Unknown <input type="checkbox"/>	
Details:	

3. Presenting Client Details (Adult) For family violence related referrals

state who the referral is for (i.e. victim-survivor, person using violence or both) if applicable, complete Section 5.

Full Name:

Address:

Email:

Mobile:

Landline:

DOB:

Gender: Male Female Self-Described Nonbinary Prefer not to answer

Role in Family (relationship status):

Does the client identify as LGBTIQ+? (if yes, refer also to Section 8)

Yes No Unknown Prefer not to say

Does the client identify as Aboriginal, Torres Strait Islander? (if yes, refer also to Section 8)

Aboriginal Torres Strait Islander Both Neither Unknown Prefer not to say

Accessibility needs (e.g. hearing or speech loss, low literacy) (If yes, refer to Section 8)

Yes No Unknown Prefer not to say

Advocate or support person requested? Yes No Unknown Prefer not to say

Is it safe to leave a message? Yes No Unknown

Additional information or safety issues in relation to contacting client:

Does the client have their own transport? Yes No Unknown

4. Presenting Client Details (Children and Young people)

Please record CRIS number for children involved with Child Protection.

Full Name:

DOB or Estimated Age:

CRIS Number:

Gender: Male Female Self-Described Nonbinary Prefer not to answer

Aboriginal and Torres Strait Islander: Aboriginal Torres Strait Islander Both Neither Unknown Prefer not to say

Does the child identify as being LGBTIQ+? Yes No Unknown Prefer not to say

Resides with presenting client Yes No Unknown

Copy and insert rows as required for additional children

5. Person using Violence (if relevant)

Full Name:

DOB:

Email:

Mobile:

Landline:

Address or Current Location:

Aboriginal and Torres Strait Islander Aboriginal Torres Strait Islander Both Neither Unknown Prefer not to say

Known history of violence?

Other relevant risk information

6. Current Situation / Previous Service History

Current Situation/Incident: (Briefly explain reasons for referral and/or recent incident prompting the referral).

Other presenting Themes and Needs: (Briefly explain presenting themes and needs, including family violence concerns, child welling concerns and parenting capacity information).

Aims / Goals of Referral: (Briefly explain client's goals, aims of referral, motivation and readiness, identified supports and safety planning).

Does the client / family have any current or recent Family Violence Service or Family Services involvement? Yes No Unknown If yes, please provide details:

Current / previous Child Protection Involvement: Yes No Unknown If yes, please provide details:

Practitioner Safety Considerations (i.e. history of violence towards workers, dangerous animals, weapons in the home, etc.)

7. Service Engagement

If consent was not provided to make this referral, what are the client's concerns with engaging with services?

How does the client feel about engaging with support services?

Substance Use Considerations

Does the client identify as having any issues of alcohol or other drug dependence?

Yes No Unknown Details:

If yes, are they receiving treatment? (i.e. opiate replacement therapy?)

Yes No Unknown Prefer not to say Details:

Legal Considerations (include relevant information regarding legal support, court orders, family law)

Details:

Medical Considerations

Does the client or any immediate family member have any medical or health concerns?

Yes No Unknown Prefer not to say Details:

Mental Health

Does the client or any immediate family member have a diagnosed mental health condition?

Yes No Unknown Prefer not to say Details:

Has the client or any member of the family expressed thoughts of self-harm or suicide?

Yes No Unknown Prefer not to say Details:

Current Housing Arrangement

Crisis Accommodation Rental Public Housing Friends / Relatives Motel Own home

Other

Is crisis accommodation required? Yes No Unknown Details:

Are there any housing stability concerns? Yes No Unknown Details:

Has the client/family previously been accommodated in:

Secure women's refuge Transitional Housing Management Crisis Property

If yes, what was the reason for leaving?

Employment Centrelink Benefit Type

CRN:

Does the client qualify for a crisis payment Yes No Unknown

Support Needs, Strengths and Cultural Considerations

The Orange Door is committed to ensuring everyone feels safe, welcomed, respected and included, the following optional questions regarding disability, cultural identity and sexuality are included to support The Orange Door to provide an inclusive response and connect people with appropriate services.

Disability Support Needs

Is the client or immediate family member living with a disability?

Yes No Unknown Prefer not to say

Details:

Is the client or any member of the family accessing the NDIS?

Yes No Unknown Prefer not to say

Details:

Aboriginal and Torres Strait Islander

Does the client or any immediate family member identify as Aboriginal, Torres Strait Islander or both Aboriginal and Torres Strait Islander? If yes, please state which family member/s identify as Aboriginal, Torres Strait Islander or both and consider the following questions regarding cultural connections

Aboriginal Torres Strait Islander Both Neither Unknown Prefer not to say

Does the client / family know where their mob is from? Please be mindful that for some people this question may be triggering due to family disconnection as a result of the Stolen Generations, remind the client that it is okay if they do not know their mob, and offer support.

Yes No Unknown Details:

Would the client / family like support to look into their cultural heritage? Yes No Unknown

Is the client / family connected to an Elder or community member? Yes No Unknown

Does the client have a preferred agency for ongoing support? Yes No Unknown

Details:

Consider where the client feels safe to be referred, also consider where family members may work or attend certain services. If family violence is present, consider where the person using violence may have been referred.

Please provide relevant information regarding support provided from community:

Refugee and Migrant background

Does the client or immediate family member identify as being from a migrant background?

Yes No Unknown Prefer not to say

Details: (Country of birth / Cultural Identity / main language spoken at home / Visa type and status / Connection to their cultural community):	
Country of birth :	Cultural Identity:
Visa type / status:	
Main language Spoken at home:	
Cultural identity of other family members	
Does the client/family have a connection to their cultural community? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>	
Would the client like support with cultural connections in the community? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Religion and Spirituality	
Does the client or immediate family members identify with a religion? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Prefer not to say <input type="checkbox"/> Details: (Are there any religious or spirituality needs or considerations support services need to be aware of?)	
LGBTIQA+	
Does the client or any immediate family member identify as LGBTIQA+? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Prefer not to say <input type="checkbox"/> Lesbian <input type="checkbox"/> Bisexual <input type="checkbox"/> Intersex <input type="checkbox"/> Queer <input type="checkbox"/> Gay <input type="checkbox"/> Trans and gender diverse <input type="checkbox"/> Questioning <input type="checkbox"/> Asexual <input type="checkbox"/> Details:	
Would the client / family like support to connect with the LGBTIQA+ community? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Details:	
Are there any safety concerns for the client regarding their LGBTIQA+ identification? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Details:	

8. Significant Others / Professional Network and Care Team

Significant Others (extended family, kin, kith, mob) provide details i.e. full name / DOB / gender / role in family / resides with client / cultural considerations / communication needs)

Details:

Professional Network / Care Team (e.g. MCHN, psychologist, psychiatrist, AOD worker, paediatrician) Insert rows as required with details of; agency / contact person / role / email / phone / date of first and last and frequency of contact)

Details:

Supporting Information and Consent

If applicable, please state if a recent home visit has been completed?

Yes Date of visit ___/___/___ No Unknown

If yes, were the children present and included in the visit? Yes No Unknown Details: (children present)

Please attach relevant pre-existing supporting documents (if available) and tick the relevant box

Safety Plan Risk Assessment Child Wellbeing Assessment Case Plan Case Notes

Genogram Technology (PSI) Other Needs Assessment Intervention Order

Details:

Authorisation for Release of Information (written consent)

I consent to the release of information about myself / my family to The Orange Door in Ovens Murray Area. I understand the information in this referral and assessment will be used by The Orange Door to provide a service to myself / my family and to make referrals to other services as agreed. I understand that for The Orange Door to undertake an assessment of the most suitable support for myself / my family, practitioners may need to gather information from other services and supports engaged with myself / my family.

Client Signature _____ Date _____

Verbal consent obtained from client (if written consent is not possible) Yes No

It is best practice for the referral to be discussed with the individual / family, however The Orange Door in Goulburn will accept referrals without consent in exceptional circumstances. On these occasions, referrals should be discussed with The Orange Door in advance.

END OF PART A – REFERRAL TO THE ORANGE DOOR

PLEASE EMAIL THIS TO oma@orangedoor.vic.gov.au