MISSION AUSTRALIA together we stand	**Triple Care Farm (TCF)** **Referral Form**	P: 02 4885 1265 F: 02 4885 2148 E: tcf@missionaustralia.com.au A: PO BOX 3070 Robertson NSW 2577

Program Details (please select which program your referral is for:	
☐ Withdrawal Program	☐ Both Withdrawal and Residential Programs
☐ Residential Program (Knights Hill)	☐ No preference for Rehabilitation Program location
☐ Residential Program (Batemans Bay)	

Details of Referrer	
Name:	Relationship to Client:
Mobile:	Work Phone:
Fax:	Email:
Current street Address:	
Postal Address *(if different from above):*	

Client Information	
Is this your first admission to TCF?	
Salutation, please circle: Miss, Mr, Mrs, Ms	First name:
Middle name:	Last name:
Is this your legal Name: ☐ Yes ☐ No	If no, what is your legal name?
Preferred name:	Identified Gender:
Date of Birth:	
Country of Birth:	
Current street Address:	
Postal Address *(if different from above):*	
Home Phone:	Mobile Phone:
Email:	

Support Network	
Support person one details:	
Salutation, please circle: Miss, Mr, Mrs, Ms	First name:
Last name:	Preferred name:
Relationship to Client:	
Current street Address:	
Postal Address *(if different from above):*	
Home Phone:	Mobile Phone:
Email:	
Support person two details:	
Salutation, please circle: Miss, Mr, Mrs, Ms:	First name:
Last name:	Preferred name:
Relationship to Client:	
Current street Address:	
Postal Address *(if different from above):*	
Home Phone:	Mobile Phone:
Email:	
In case of Emergency Contact	
Salutation, please circle: Miss, Mr, Mrs, Ms:	First name:
Last name:	Preferred name:
Relationship to Client:	
Current street Address:	
Postal Address *(if different from above):*	
Home Phone:	Mobile Phone:
Email:	

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Support Agencies (if applicable)	
☐ Department of Community and Justice (DCJ)	☐ Mission Australia
☐ Doctor / General Practitioner	☐ National Disability Insurance Scheme (NDIS)
☐ Juvenile Justice	☐ Community Corrections
☐ Mental Health Services	☐ Drug and Alcohol Services
☐ Other; *please state:*	
Support agencies one details:	
Salutation, please circle: Miss, Mr, Mrs, Ms:	First name:
Last name:	Preferred name:
Current street Address:	
Postal Address *(if different from above):*	
Home Phone:	Mobile Phone:
Email:	
Support agencies two details:	
Salutation, please circle: Miss, Mr, Mrs, Ms:	First name:
Last name:	Preferred name:
Current street Address:	
Postal Address *(if different from above):*	
Home Phone:	Mobile Phone:
Email:	

Personal Details			
Gender Identity:		**Sexual Orientation:**	
☐ Prefer not to answer	☐ Non-binary	☐ Prefer not to answer	☐ Pan Sexual
☐ Female	☐ Transgender	☐ Asexual	☐ Queer
☐ Male	☐ Other; please state:	☐ Bisexual	☐ Questioning
☐ Gender Diverse		☐ Gay	☐ Straight
		☐ Heterosexual	☐ Other; please state:
		☐ Lesbian	

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Indigenous Status:

☐ Aboriginal
☐ Torres Strait Islander
☐ Both Aboriginal & Torres Strait Islander
☐ Neither Aboriginal nor Torres Strait Islander
☐ Prefer not to say / not known

Culturally/Linguistically Diverse (CALD): ☐ Yes ☐ No ☐ Prefer not to say	**Do you identify with any cultural background?**
Country of Birth: ☐ Australia – Suburb born: ☐ Other, please state:	**If you were not born in Australia, how long have you been living in Australia:** ☐ Less than 12 months ☐ 1 – 5 Years ☐ More than 5 years ☐ Prefer not to say
What Languages do you speak?	**How would you rate your ability to speak English?** ☐ Fluent / Excellent ☐ Average, functional in most situations ☐ Able to speak little, some difficulties ☐ Very poor
How would you rate your ability to speak (other language identified)? ☐ Fluent / Excellent ☐ Average, functional in most situations ☐ Able to speak little, some difficulties ☐ Very poor	**Do you require an interpreter?** ☐ Yes ☐ No ☐ Unsure
Preferred language:	
Do you have any disabilities?	**Religion?**
Have you attempted suicide? ☐ Yes ☐ No	**Do you engage in self- injury?** ☐ Yes ☐ No
Have you been in Hospital for Mental Health within the last 2 years? ☐ Yes ☐ No	

Identification Information		
Medicare Number: (10 numbers)	Your Medicare reference: (1 digit)	Medicare Expiry Date:
Health Care Card Number:		Health Care Card Expiry:
Centrelink CRN:		Tax File Number:
Unique Student Identifier Number: (USI)		Do you have a Birth Certificate: ☐ yes ☐ No

Presenting Matters		
Substance Use ☐ Yes ☐ No	**Alcohol Use** ☐ Yes ☐ No	**Gambling** ☐ Yes ☐ No
Criminal History: ☐ Yes ☐ No	**Aggression/Violence history** ☐ Yes ☐ No	**Police Charges/Outstanding Matters** ☐ Yes ☐ No
Current Apprehended Violence Orders (AVO's) ☐ Yes ☐ No	**Do you have a community treatment order (CTO)?** ☐ Yes ☐ No If yes; please provide details:	**Any current Probation / Parole or Bail conditions in place:** ☐ Yes ☐ No If yes, please provide details:

Education and Employment	
Income Status: ☐ Unemployment benefits ☐ Employed ☐ Disability support Pension ☐ Parental Support ☐ Study benefits ☐ Homeless Benefits ☐ No Income ☐ Other; please state:	**Employment Status:** ☐ Full time ☐ Part time ☐ Casual ☐ Internship ☐ Volunteer ☐ Work experience ☐ Unemployed
Why did you leave school?	
Have you completed/or are you enrolled in any other education or training courses? ☐ Yes ☐ No	**Have you been employed before?** ☐ Yes ☐ No
Highest Level of Education: ☐ Year 7 or below ☐ Year 8 or equivalent ☐ Year 9 or equivalent ☐ Year 10 or equivalent ☐ Year 11 or equivalent ☐ Year 12 or equivalent ☐ Did not go to school ☐ Certificate II	**Reading Ability (1 – 10 scale):** **Writing Ability (1 – 10 scale):** **1 being low** **10 being highest**

☐ Certificate III ☐ Other; please state:	
Accommodation Status	
Living Arrangements ☐ Alone ☐ Spouse/partner ☐ Alone with child(ren) ☐ Other relatives ☐ Friend(s) / Parent(s) ☐ Other	**Have you ever experienced homelessness or transience?** ☐ Yes ☐ No
Family Background	
Family details including history and siblings:	
Marital/Relationship Status: ☐ De facto ☐ Divorced ☐ Married ☐ Separated ☐ In a relationship ☐ Single ☐ Widowed	**Do you have any children?** ☐ Yes ☐ No
Medical Information	
Medical Conditions:	**Prescribed Medications:**

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Thank you for your referral!

The team at Triple Care Farn will aim to be in touch over the next few business days to discuss the next steps. In the meantime, if you have any further questions please don't hesitate to call on (02) 4885 1265. If there is any additional information that you think should be shared that hasn't been covered, please let us know.

Please be advised that you may also be asked to provide any relevant criminal history and/or recent hospital discharge summaries. At times, this information is required so that TCF may be able to best support you. Whilst we hope to avoid a delay, if we don't receive this information, it may unfortunately result in a pause to the intake process. So, please let us know if you have any barriers in obtaining them, and we will try and work this through with you.

Name of Referrer:	**Signature:**	**Date:**

. . .

Staff/office use only		
Date referral received:	**Receiving Staff member:**	**Contact made with Client:** ☐ Yes ☐ No