2C RISK ASSESSMENT FORM

Triple Care Farm: AOD Rehabilitation Program

P: 02 4885 1265 **F:** 02 4885 1563

E: TCF@missionaustralia.com.au

M: PO BOX 3070 Robertson NSW 2577

(Form can be completed as a word document and emailed to TCF or printed and information written)

Date risk assessment completed:	Date referral received (TCF to complete):

CLIENT INFORMATION:

Client's last name:	First:	Middle:
Birth date:	Age:	Sex: M F
Current street address:		Home phone no.: ( ) Mobile:

RISK ASSESSMENT COMPLETED BY

(Must be completed by FACS, Health, Justice or other referring agencies):

Name:	Relationship to client:	Phone number: ( )
Street address:	Fax number:	Mobile number:
P.O. Box:	City:	State: Postcode:

HOW LONG IS THE YOUNG PERSON EXPECTED TO BE UNDER YOUR CARE SUPERVISION?

HOW DID THE YOUNG PERSON COME INTO CONTACT WITH YOUR SERVICE?

DETAILED HISTORY OF YOUNG PERSON'S PLACEMENTS OVER THE PAST 2 YEARS, SPECIFYING LENGTH IN EACH PLACEMENT:

DETAILED HISTORY OF INVOLVEMENT WITH FACS OR JUSTICE

Including complete history of previous care orders/offences and charges pending:

CURRENT (FACS/JUSTICE) CARE/SUPERVISION CONTROL OF BAIL ORDERS, COMMUNITY TREATMENT ORDERS

Please detail all relevant information regarding current order:

DETAILS OF ANY PAST INCIDENTS OF VIOLENT BEHAVIOUR OR CHRONIC PROBLEMS WITH VIOLENT BEHAVIOUR:

HAS THIS CLIENT HAD A HISTORY OF SUICIDAL ATTEMPTS, SELF HARM OR THREATS. PLEASE OUTLINE DETAILS, PAST TREATMENT AND CURRENT CONCERNS:

HAS THIS CLIENT HAD A HISTORY OF BEHAVIOURAL PROBLEMS OR PSYCHIATRIC ILLNESS? IS THE CLIENT CURRENTLY ON MEDICATION FOR ANY PSYCHIATRIC DISORDER OR BEHAVIOUR PROBLEM? PLEASE DETAIL:

LIST PSYCHIATRIST/S THE CLIENT HAS BEEN IN CARE/CONTACT WITH?

Name:	Contact details:
Dates of contacts:	
Name:	Contact details:
Dates of contacts:	

WHAT DO YOU CONSIDER THE BENEFITS FOR THIS YOUNG PERSON PARTICIPATING IN THE TRIPLE CARE FARM PROGRAM?

Please detail all relevant information regarding current order:

WHAT WOULD THE LEGAL CONSEQUENCES OF NOT BEING ACCEPTED INTO THE PROGRAM:

LIST DETAILS OF SUPPORT YOU WILL PROVIDE FOR THE YOUNG PERSON WHILST AT TRIPLE CARE FARM:

Completed by: Name: Signature:	Date:
Manager: Name: Signature:	Date: