

2C RISK ASSESSMENT FORM

Triple Care Farm: AOD Rehabilitation Program

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(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):
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CLIENT INFORMATION:

Client's last name:	First:	Middle:
Birth date:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> 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?

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

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

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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: