APPLICATION FORM

Triple Care Farm – Withdrawal, Residential Rehabilitation & Aftercare Program

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

E: TCF@missionaustralia.com.au

M: PO BOX 3070 Robertson NSW 2577

Please tick which program your referral is for:

Withdrawal ___ Residential Rehabilitation ___ Both Withdrawal & Residential Rehabilitation ___

If you are unsure, please call (02) 4885 1265 to discuss the options.

Date Referral Received (TCF to complete):

CLIENT INFORMATION

Client's last name:	First: Preferred Name:	Middle:
Is this your legal name? Yes No	If not, what is your legal name?	Former name:
Birth date:		Age:
First Admission: Yes No		

Current Gender Identity: Female Male Non-Binary Different Identity: Please state: Prefer not to say:	Gender Assigned at Birth: Female Male Prefer not to say	Are You Intersex: Yes No Prefer not to say	Sexual Orientation: Lesbian, gay or homosexual. Straight or heterosexual Bisexual Different identity Please state: Prefer not to say

Current Street address: Postcode:	Home phone no:
Postal Address: Tick if same as above	Mobile:
Email Address:	

DETAILS OF REFERRER (SELF REFERRER'S DO NOT NEED TO COMPLETE)

Referrer's Name:	Work phone no:
Relationship to client:	
Street address: Postal Address: Tick if same as above	Mobile:
Email address:	Fax No.

SUPPORT NETWORK INFORMATION

Guardian 1 Name:	Address:	Home phone no: Mobile:
Guardian 2 Name:	Address: Tick if same as above	Home phone no:
Other Support Person Name: Relationship:	Address: Tick if same as above	Home phone no: Mobile:

IN CASE OF EMERGENCY

Contact Name: Relationship with client:	Address: Tick if same as above	Home phone no: Mobile:

SUPPORT AGENCIES INVOLVED

PLEASE TICK APPLICABLE BOXES AND PROVIDE DETAILS: AGENCIES LISTED MUST PROVIDE A RISK ASSESSMENT

Family and Community Services (FACS)	Mission Australia	Doctor	Other
NDIS Provider Details:	Justice: Juvenile Justice Community Corrections	Health Service (LHD) Mental Health Drug Health	Other

Agency 1 Contact Name:	Relationship to client:	Work phone no:
Street address:		Mobile:
Postal Address: Tick if same as above		Fax No.
Agency 2 Contact Name:	Relationship to client:	Work phone no:
Street address:		Mobile:
Postal Address: Tick if same as above		Fax No.

IDENTIFICATION INFORMATION

Do you have a Birth Certificate Yes No

Medicare Number: Number reference on card: Expiry date:	Tax File Number: Centre link CRN:

MEDICAL INFORMATION

Significant Medical Condition:	Ongoing prescribed medications:
Any known allergies? Yes No	Details: Reaction:
Hospital admission for Mental Health within the last 2 years Yes No Don't Know	If yes, please provide a copy the hospital discharge summary. Failure to provide will delay admittance to the program.
Do you have a Community Treatment Order? Yes No Don't Know	If yes, please provide a copy. Failure to provide will delay admittance to the program.

PERSONAL INFORMATION

Country of birth:	Preferred Language:
Cultural/Linguistically Diverse (CALD) background: Yes No	Details:
Requires an interpreter: Yes No	Language:
Have any disabilities: Yes No	Details:
Identifi s as Aboriginal: Yes No	Identifies as Torres Strait Islander Identifies as Aboriginal and Torres Strait Islander

INCOME STATUS

Unemployment Benefi	Parental Support	Study Benefi	Homeless Benefi
Full time employment	Part time employment	Casual Employment	No income
Disability Support Pension	Other: (Details)		

BACKGROUND

Has the client experienced:	Attempted Suicide: Yes No Don't Know Self-Harm Yes No Don't Know	Details (including dates): Details: (including dates):
Presenting Issue:	Drug Abuse: Yes No Don't Know	Details:
	Alcohol Abuse: Yes No Don't Know	Details:
	Gambling: Yes No Don't Know	Details:

LEGAL

Criminal history: Yes No Don't Know	If yes, please provide a copy of criminal history. Failure to will delay admittance to the program.
Any acts of aggression/violence in the criminal history? Yes No Don't Know	If yes, please provide police facts. Failure to provide will delay admittance to the program.
Any police charges, outstanding matters, court dates: Yes No	Details:

FAMILY BACKGROUND

Family details including history and siblings:

The above information is true to the best of my knowledge.

Client/Referrers Signature: Date: