

Triple Care Farm (TCF) Referral Form

P: 02 4885 1265
 F: 02 4885 2148
 E: tcf@missionaustralia.com.au
 A: PO BOX 3070
 Knights Hill NSW 2577

Program Details (please select which program your referral is for):

- | | |
|---|--|
| <input type="checkbox"/> Withdrawal Program | <input type="checkbox"/> Both Withdrawal and Residential Programs |
| <input type="checkbox"/> Residential Program (Knights Hill) | <input type="checkbox"/> No preference for Rehabilitation Program location |
| <input type="checkbox"/> Residential Program (Batemans Bay) | |

To avoid delays in the progress of your application, please attach any relevant criminal history and/or recent hospital discharge summaries to your referral. This information may be necessary to help TCF best support you.

Details of Referrer

Name:	Relationship to Client:
Mobile:	Work Phone:
Fax:	Email:
Current street Address:	
Postal Address <i>(if different from above)</i> :	

Client Information

Is this your first admission to Triple Care Farm?	
Salutation: Miss, Mr, Mrs, Ms	First name:
Middle name:	Last name:
Is this your legal Name: <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, what is your legal name?
Preferred name:	Identified Gender:
Marital Status:	Date of Birth:
Country of Birth:	
Current street Address:	
Postal Address <i>(if different from above)</i> :	
Home Phone:	Mobile Phone:
Email:	

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Support Network

Support person one details:

Salutation: 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: 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: 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:

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Support Agencies (if applicable)

<input type="checkbox"/> Department of Community and Justice (DCJ)	<input type="checkbox"/> Mission Australia
<input type="checkbox"/> Doctor / General Practitioner	<input type="checkbox"/> National Disability Insurance Scheme (NDIS)
<input type="checkbox"/> Juvenile Justice / Community Corrections	<input type="checkbox"/> Legal Aid / Solicitor
<input type="checkbox"/> Mental Health Services	<input type="checkbox"/> Drug and Alcohol Services
<input type="checkbox"/> Other; <i>please state:</i>	

Support agencies one details:

Salutation Miss, Mr, Mrs, Ms:	First name:
Last name:	Preferred name:
Current street Address:	
Postal Address (<i>if different from above</i>):	
Home Phone:	Mobile Phone:
Email:	

Support agencies two details:

Salutation: Miss, Mr, Mrs, Ms:	First name:
Last name:	Preferred name:
Current street Address:	
Postal Address (<i>if different from above</i>):	
Home Phone:	Mobile Phone:
Email:	

Personal Details

Gender Identity: <input type="checkbox"/> Prefer not to answer <input type="checkbox"/> Non-binary <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Male <input type="checkbox"/> Other; please state: <input type="checkbox"/> Gender Diverse	Sexual Orientation: <input type="checkbox"/> Prefer not to answer <input type="checkbox"/> Pan Sexual <input type="checkbox"/> Asexual <input type="checkbox"/> Queer <input type="checkbox"/> Bisexual <input type="checkbox"/> Questioning <input type="checkbox"/> Gay <input type="checkbox"/> Straight <input type="checkbox"/> Heterosexual <input type="checkbox"/> Other; please state: <input type="checkbox"/> Lesbian
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Indigenous Status: <input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Both Aboriginal & Torres Strait Islander		<input type="checkbox"/> Neither Aboriginal nor Torres Strait Islander <input type="checkbox"/> Prefer not to say / not known	
Culturally/Linguistically Diverse (CALD): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Prefer not to say		Do you identify with any cultural background?	
Country of Birth: <input type="checkbox"/> Australia – Suburb born: <input type="checkbox"/> Other, please state:		If you were not born in Australia, how long have you been living in Australia: <input type="checkbox"/> Less than 12 months <input type="checkbox"/> 1 – 5 Years <input type="checkbox"/> More than 5 years <input type="checkbox"/> Prefer not to say	
What Languages do you speak?		How would you rate your ability to speak English? <input type="checkbox"/> Fluent / Excellent <input type="checkbox"/> Average, functional in most situations <input type="checkbox"/> Able to speak little, some difficulties <input type="checkbox"/> Very poor	
How would you rate your ability to speak (other language identified)? <input type="checkbox"/> Fluent / Excellent <input type="checkbox"/> Average, functional in most situations <input type="checkbox"/> Able to speak little, some difficulties <input type="checkbox"/> Very poor		Do you require an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	
Preferred language:			
Do you have any disabilities?		Religion?	
Identification Information			
Medicare Number: (10 numbers)		Your Medicare reference: (1 digit)	Medicare Expiry Date:
Health Care Card Number:		Expiry:	Tax File Number:
Centrelink CRN:		Unique Student Identifier Number: (USI)	
Do you have a Photo ID: <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you have a Birth Certificate: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have a MIN or PID number? <input type="checkbox"/> Yes <input type="checkbox"/> No Number:			
Presenting Matters			
Substance Use <input type="checkbox"/> Yes <input type="checkbox"/> No	Alcohol Use <input type="checkbox"/> Yes <input type="checkbox"/> No		Gambling <input type="checkbox"/> Yes <input type="checkbox"/> No

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Attempted Suicide: <input type="checkbox"/> Yes <input type="checkbox"/> No	Self-Harm: <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you been in Hospital for Mental Health within the last 2 years? <input type="checkbox"/> Yes <input type="checkbox"/> No
Criminal History: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes; please provide details:</i>	Aggression/Violence history <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes; please provide details:</i>	Police Charges/Outstanding Matters <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes; please provide details:</i>
Current Apprehended Violence Orders (AVO's) <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes; please provide details:</i>	Do you have a community treatment order (CTO)? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes; please provide details:</i>	Any current Probation / Parole or Bail conditions in place: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please provide details:</i>

Education and Employment

Income Status: <input type="checkbox"/> Unemployment benefits <input type="checkbox"/> Employed <input type="checkbox"/> Disability support Pension <input type="checkbox"/> Parental Support <input type="checkbox"/> Study benefits <input type="checkbox"/> Homeless Benefits <input type="checkbox"/> No Income <input type="checkbox"/> Other; please state:	Employment Status: <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Casual <input type="checkbox"/> Internship <input type="checkbox"/> Volunteer <input type="checkbox"/> Work experience <input type="checkbox"/> Unemployed
Why did you leave school?	
Have you completed/or are you enrolled in any other education or training courses? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you been employed before? <input type="checkbox"/> Yes <input type="checkbox"/> No
Highest Level of Education: <input type="checkbox"/> Year 7 or below <input type="checkbox"/> Year 8 or equivalent <input type="checkbox"/> Year 9 or equivalent <input type="checkbox"/> Year 10 or equivalent <input type="checkbox"/> Year 11 or equivalent <input type="checkbox"/> Year 12 or equivalent <input type="checkbox"/> Did not go to school <input type="checkbox"/> Certificate II <input type="checkbox"/> Certificate III <input type="checkbox"/> Other; please state:	Reading Ability (1 – 10 scale): Writing Ability (1 – 10 scale): <p style="color: #e91e63; margin-top: 10px;">1 being low 10 being highest</p>

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Accommodation Status

Living Arrangements

- Alone
- Friend(s)
- Friend(s) parents/relative(s) and children
- Other relatives
- Parent(s)
- Spouse/partner
- Spouse/partner and child(ren)
- Single parent with child(ren)

Conditions of Occupancy

- Boarder
- Couch surfer
- Lease in place – not nominated on lease
- Lease tenure – nominated on lease
- Living with relative fee free
- Not Applicable
- 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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The team at Triple Care Farm will aim to be in touch as soon as possible 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.

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Name of Referrer:	Signature:	Date:
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If you are accepted into Triple Care Farm, who will be responsible for paying the rent, pharmacy, or any other associated costs during your stay?

Name:	Postal Address:
Phone:	Email:

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