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 Knights Hill 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)	

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 *(if different from above):*	

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: ☐ Yes ☐ 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 *(if different from above):*	
Home Phone:	Mobile Phone:
Email:	

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:
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	☐ Legal Aid / Solicitor
☐ Mental Health Services	☐ Drug and Alcohol Services
☐ Other; *please state:*	
Support agencies one details:	
Salutation 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: 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	

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?**

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: ☐ Yes ☐ No	Do you have a Birth Certificate: ☐ Yes ☐ No	
Do you have a MIN or PID number? ☐ Yes ☐ No Number:		

Presenting Matters		
Substance Use ☐ Yes ☐ No	**Alcohol Use** ☐ Yes ☐ No	**Gambling** ☐ Yes ☐ No

Attempted Suicide: ☐ Yes ☐ No	**Self-Harm:** ☐ Yes ☐ No	**Have you been in Hospital for Mental Health within the last 2 years?** ☐ Yes ☐ No
Criminal History: ☐ Yes ☐ No *If yes; please provide details:*	**Aggression/Violence history** ☐ Yes ☐ No *If yes; please provide details:*	**Police Charges/Outstanding Matters** ☐ Yes ☐ No *If yes; please provide details:*
Current Apprehended Violence Orders (AVO's) ☐ Yes ☐ No *If yes; please provide details:*	**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 ☐ Certificate III ☐ Other; please state:	**Reading Ability (1 – 10 scale):** **Writing Ability (1 – 10 scale):** **1 being low** **10 being highest**

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:**

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:**

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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