Text

Description automatically generatedChildren and Youth Counselling

Referral Form

GenWest counselling program provides counselling interventions for children, young people and families who have been impacted by family violence in the western metropolitan region.

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| Eligibility criteria for counselling referrals: *If a referral does not meet the criteria listed, please contact the counselling team via* [*counselling@genwest.org.au*](mailto:counselling@genwest.org.au) *or call 08 9689 9588 to arrange a consult.* | |
| * The child/young person is aged between 0 and 17 years. |  |
| * The main reason for counselling is recovery from the impacts of family violence. |  |
| * The child/young person does not live with the person using violence |  |
| * The child/young person’s primary carer has access to support and can engage in the counselling process. |  |
| * A current **adult** Family Violence Risk Assessment is attached |  |
| * A current **child** Family Violence Risk Assessment is attached *(if completed)* | **☐** |

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| Referring Agency | | | |
| Agency name: |  | Date: |  |
| Referrer name: |  | Phone number: |  |
| Email address: |  | | |
| Support provided: |  | | |

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| Primary Carer Details | | | | | | | | |
| Name: |  | | | | Date of birth: | |  | |
| Relationship to child/young person: |  | | | | | | | |
| Gender identity: |  | | | | Country of birth: | |  | |
| Residency status: | Citizen/Permanent Resident  Temporary visa  Bridging visa  Other: | | | | | | | |
| Address: |  | | | | | | | |
| Phone number: |  | | | | Email address: | |  | |
| Safety issues with contact details: | | | |  | | | | |
| First Nations Status: | | Aboriginal  Torres Strait Islander  Both  Neither | | | | | | |
| Cultural identity: |  | | | | Spiritual Practice: | |  | |
| Language spoken at home: | | |  | | Interpreter required? | | | Yes  No |
| **Further Information:** | | | | | | | | |
| Disability? | | | Yes  No | | | | | |
| If yes, please add details: | | |  | | | | | |
| Is the primary carer engaged in counselling/therapeutic support? | | | | | | Yes  No  Previous | | |
| If yes, primary carer’s current/previous counselling/therapeutic involvement: | | |  | | | | | |
| Preferred location for counselling: | | | | Footscray  Wyndham Vale  Melton | | | | |

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| Who lives in the house? *Family living description* | | |
| **Members living with primary carer:** | | |
| Name: | Age: | Relationship to primary carer: |
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| **Immediate family members not living with primary carer:** | | |
| Name: | Age: | Relationship to primary carer: |
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| Person using violence | |
| Name of Person using violence: |  |
| Relationship to child/young person: |  |
| Gender identity: |  |
| Date of separation: |  |
| Residency Status: | Citizen/Permanent Resident  Temporary visa  Bridging visa  Other: |
| Another Person using Violence (if applicable) | |
| Name of Person using violence: |  |
| Relationship to child/young person: |  |
| Gender identity: |  |
| Date of separation: |  |
| Residency Status: | Citizen/Permanent Resident  Temporary visa  Bridging visa  Other: |

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| Legal Details | | | | |
| Intervention order (IVO)? | Yes  No | | Are children listed on intervention order (IVO)? | Yes  No |
| Length of order comments/expiry: |  | | | |
| Are there any formal or informal access arrangements with the person using violence? | | | | Yes  No |
| Details: | *How often do they see/speak to the person using violence. How is contact arranged?* | | | |
| Family court proceedings? | *None* *In Progress* *Mediation* *Court Order Made* | | | |
| Details: |  | | | |
| **Please note that GenWest are unable to provide reports for Family Court.** | | | | |
| Current child protection involvement?  Please add details: | |  | | |
| Historical child protection involvement? Please add details: | |  | | |
| If yes, are there children’s court orders in place? | | Yes  No | | |
| Please list additional details: | |  | | |
| **Additional Information**  List any other relevant information: | | | | |
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| Child/Young Person’s Experience of Family Violence | |
| Experiences of DIRECT violence  *(Violence directed at them)* | **Experiences of INDIRECT violence**  *(Violence witnessed)* |
| Social  Verbal  Emotional  Spiritual  Physical  Sexual  Financial  Technological | Social  Verbal  Emotional  Spiritual  Physical  Sexual  Financial  Technological |
| Details: | **Details:** |
| Please provide details of the most recent incident of family violence, including the date, and any safety plans put in place: | |
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| Child/Young Person Details (first or only child/young person) | | | | | | | | | | | |
| Name: |  | | | | | | Date of birth: | | |  | |
| Gender identity: |  | | | | | | Country of birth: | | |  | |
| Residency status: | Citizen/Permanent Resident  Temporary visa  Bridging visa  Other: | | | | | | | | | | |
| First Nations Status: | | | Aboriginal  Torres Strait Islander  Both  Neither | | | | | | | | |
| Cultural identity: |  | | | | | Spiritual Practice: | | |  | | |
| Language spoken at home: | | | |  | | | Interpreter required? | | | | Yes  No |
| **Further Information:** | | | | | | | | | | | |
| Disability? | | Yes  No  Details: | | | | | | | | | |
| Additional needs? | | Yes  No  Details: | | | | | | | | | |
| Name of School: | |  | | | | | | | | | |
| Child fully vaccinated?  *(This relates to general vaccinations and does not affect access to service)* | | | | | | | | Yes  No | | | |
| Is child/young person aware of referral? | | | | | | | | Yes  No | | | |
| Has the child/young person received counselling before? | | | | | | | | Yes  No | | | |
| **Behaviour/Presentation of Child/Young Person**  *The asterisk (\*) identifies behaviours that must include further information below.* | | | | | | | | | | | |
| **Concerning Behaviour** | | | | | **Details** *(What does the behaviour look like? How often does it occur?)* | | | | | | |
| Often complains of feeling unwell. | | | | |  | | | | | | |
| Difficulty separating? | | | | |  | | | | | | |
| Sleep problems or worries at night? | | | | |  | | | | | | |
| Lots of fears and worries? | | | | |  | | | | | | |
| Delayed milestones? | | | | |  | | | | | | |
| Reclusive or withdrawn behaviour? | | | | |  | | | | | | |
| Sexualised behaviour? \* | | | | |  | | | | | | |
| Aggressive behaviour/acting out? \* | | | | |  | | | | | | |
| Lack of boundaries with strangers? | | | | |  | | | | | | |
| Eating problems? | | | | |  | | | | | | |
| Running away from home/school? | | | | |  | | | | | | |
| Developmental regression  (bed-wetting/soiling)? | | | | |  | | | | | | |
| Not many friends/bullying? | | | | |  | | | | | | |
| School/concentration difficulties? | | | | |  | | | | | | |
| Self-harm/suicidal thoughts? \* | | | | |  | | | | | | |
| Low self-image, says “I’m bad”? | | | | |  | | | | | | |
| **Any further details:** | | | | | | | | | | | |
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| Child/Young Person 2 Details *(delete if not applicable)* | | | | | | | | | | | |
| Name: |  | | | | | | Date of birth: | | |  | |
| Gender identity: |  | | | | | | Country of birth: | | |  | |
| Residency status: | Citizen/Permanent Resident  Temporary visa  Bridging visa  Other: | | | | | | | | | | |
| First Nations Status: | | | Aboriginal  Torres Strait Islander  Both  Neither | | | | | | | | |
| Cultural identity: |  | | | | | Spiritual Practice: | | |  | | |
| Language spoken at home: | | | |  | | | Interpreter required? | | | | Yes  No |
| **Further Information:** | | | | | | | | | | | |
| Disability? | | Yes  No  Details: | | | | | | | | | |
| Additional needs? | | Yes  No  Details: | | | | | | | | | |
| Name of School: | |  | | | | | | | | | |
| Child fully vaccinated?  *(This relates to general vaccinations and does not affect access to service)* | | | | | | | | Yes  No | | | |
| Is child/young person aware of referral? | | | | | | | | Yes  No | | | |
| Has the child/young person received counselling before? | | | | | | | | Yes  No | | | |
| **Behaviour/Presentation of Child/Young Person**  *The asterisk (\*) identifies behaviours that must include further information below.* | | | | | | | | | | | |
| **Concerning Behaviour** | | | | | **Details** *(What does the behaviour look like? How often does it occur?)* | | | | | | |
| Often complains of feeling unwell. | | | | |  | | | | | | |
| Difficulty separating? | | | | |  | | | | | | |
| Sleep problems or worries at night? | | | | |  | | | | | | |
| Lots of fears and worries? | | | | |  | | | | | | |
| Delayed milestones? | | | | |  | | | | | | |
| Reclusive or withdrawn behaviour? | | | | |  | | | | | | |
| Sexualised behaviour? \* | | | | |  | | | | | | |
| Aggressive behaviour/acting out? \* | | | | |  | | | | | | |
| Lack of boundaries with strangers? | | | | |  | | | | | | |
| Eating problems? | | | | |  | | | | | | |
| Running away from home/school? | | | | |  | | | | | | |
| Developmental regression  (bed-wetting/soiling)? | | | | |  | | | | | | |
| Not many friends/bullying? | | | | |  | | | | | | |
| School/concentration difficulties? | | | | |  | | | | | | |
| Self-harm/suicidal thoughts? \* | | | | |  | | | | | | |
| Low self-image, says “I’m bad”? | | | | |  | | | | | | |
| **Any further details:** | | | | | | | | | | | |
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| Child/Young Person 3 Details *(delete if not applicable)* | | | | | | | | | | | |
| Name: |  | | | | | | Date of birth: | | |  | |
| Gender identity: |  | | | | | | Country of birth: | | |  | |
| Residency status: | Citizen/Permanent Resident  Temporary visa  Bridging visa  Other: | | | | | | | | | | |
| First Nations Status: | | | Aboriginal  Torres Strait Islander  Both  Neither | | | | | | | | |
| Cultural identity: |  | | | | | Spiritual Practice: | | |  | | |
| Language spoken at home: | | | |  | | | Interpreter required? | | | | Yes  No |
| **Further Information:** | | | | | | | | | | | |
| Disability? | | Yes  No  Details: | | | | | | | | | |
| Additional needs? | | Yes  No  Details: | | | | | | | | | |
| Name of School: | |  | | | | | | | | | |
| Child fully vaccinated?  *(This relates to general vaccinations and does not affect access to service)* | | | | | | | | Yes  No | | | |
| Is child/young person aware of referral? | | | | | | | | Yes  No | | | |
| Has the child/young person received counselling before? | | | | | | | | Yes  No | | | |
| **Behaviour/Presentation of Child/Young Person**  *The asterisk (\*) identifies behaviours that must include further information below.* | | | | | | | | | | | |
| **Concerning Behaviour** | | | | | **Details** *(What does the behaviour look like? How often does it occur?)* | | | | | | |
| Often complains of feeling unwell. | | | | |  | | | | | | |
| Difficulty separating? | | | | |  | | | | | | |
| Sleep problems or worries at night? | | | | |  | | | | | | |
| Lots of fears and worries? | | | | |  | | | | | | |
| Delayed milestones? | | | | |  | | | | | | |
| Reclusive or withdrawn behaviour? | | | | |  | | | | | | |
| Sexualised behaviour? \* | | | | |  | | | | | | |
| Aggressive behaviour/acting out? \* | | | | |  | | | | | | |
| Lack of boundaries with strangers? | | | | |  | | | | | | |
| Eating problems? | | | | |  | | | | | | |
| Running away from home/school? | | | | |  | | | | | | |
| Developmental regression  (bed-wetting/soiling)? | | | | |  | | | | | | |
| Not many friends/bullying? | | | | |  | | | | | | |
| School/concentration difficulties? | | | | |  | | | | | | |
| Self-harm/suicidal thoughts? \* | | | | |  | | | | | | |
| Low self-image, says “I’m bad”? | | | | |  | | | | | | |
| **Any further details:** | | | | | | | | | | | |
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| Child/Young Person 4 Details *(delete if not applicable)* | | | | | | | | | | | |
| Name: |  | | | | | | Date of birth: | | |  | |
| Gender identity: |  | | | | | | Country of birth: | | |  | |
| Residency status: | Citizen/Permanent Resident  Temporary visa  Bridging visa  Other: | | | | | | | | | | |
| First Nations Status: | | | Aboriginal  Torres Strait Islander  Both  Neither | | | | | | | | |
| Cultural identity: |  | | | | | Spiritual Practice: | | |  | | |
| Language spoken at home: | | | |  | | | Interpreter required? | | | | Yes  No |
| **Further Information:** | | | | | | | | | | | |
| Disability? | | Yes  No  Details: | | | | | | | | | |
| Additional needs? | | Yes  No  Details: | | | | | | | | | |
| Name of School: | |  | | | | | | | | | |
| Child fully vaccinated?  *(This relates to general vaccinations and does not affect access to service)* | | | | | | | | Yes  No | | | |
| Is child/young person aware of referral? | | | | | | | | Yes  No | | | |
| Has the child/young person received counselling before? | | | | | | | | Yes  No | | | |
| **Behaviour/Presentation of Child/Young Person**  *The asterisk (\*) identifies behaviours that must include further information below.* | | | | | | | | | | | |
| **Concerning Behaviour** | | | | | **Details** *(What does the behaviour look like? How often does it occur?)* | | | | | | |
| Often complains of feeling unwell. | | | | |  | | | | | | |
| Difficulty separating? | | | | |  | | | | | | |
| Sleep problems or worries at night? | | | | |  | | | | | | |
| Lots of fears and worries? | | | | |  | | | | | | |
| Delayed milestones? | | | | |  | | | | | | |
| Reclusive or withdrawn behaviour? | | | | |  | | | | | | |
| Sexualised behaviour? \* | | | | |  | | | | | | |
| Aggressive behaviour/acting out? \* | | | | |  | | | | | | |
| Lack of boundaries with strangers? | | | | |  | | | | | | |
| Eating problems? | | | | |  | | | | | | |
| Running away from home/school? | | | | |  | | | | | | |
| Developmental regression  (bed-wetting/soiling)? | | | | |  | | | | | | |
| Not many friends/bullying? | | | | |  | | | | | | |
| School/concentration difficulties? | | | | |  | | | | | | |
| Self-harm/suicidal thoughts? \* | | | | |  | | | | | | |
| Low self-image, says “I’m bad”? | | | | |  | | | | | | |
| **Any further details:** | | | | | | | | | | | |
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| Other Agencies  *List any other agencies involved with family and provide contact details below:* | |
| Agency name: |  |
| Worker name: |  |
| Contact details: |  |
| Reason for involvement: |  |
| **Another Agency (if applicable)** | |
| Agency name: |  |
| Worker name: |  |
| Contact details: |  |
| Reason for involvement: |  |
| **Another Agency (if applicable)** | |
| Agency name: |  |
| Worker name: |  |
| Contact details: |  |
| Reason for involvement: |  |
| **Another Agency (if applicable)** | |
| Agency name: |  |
| Worker name: |  |
| Contact details: |  |
| Reason for involvement: |  |

**Please attach an up-to-date risk assessment with any other relevant information and forward the referral to GenWest.**

**Email:** [counselling@genwest.org.au](mailto:counselling@genwest.org.au)

**Phone:** 1800 436 937