Children 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* *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

**Phone:** 1800 436 937