

FELLA'S FAMILY PROJECT

YOUNG MALE SUPPORT

PO BOX 128
64 CRANE STREET
BALLINA NSW 2478
PH/FAX: 02 66864109
youthsupport@bbfc.com.au

REFERRAL FORM



CRITERIA: The young person who the service is requested for must:

- Be a male who resides in either the Ballina or Byron Shires.
- Be between the ages of 11 and 16 years.

DATE OF CONTACT: _____

CLIENT NO: _____

YOUNG PERSON'S NAME: _____ ATSI: CALD:

D.O.B: _____ AGE: _____ PHONE: _____

ADDRESS: _____

BRIEF OUTLINE OF PRESENTING ISSUES: _____

ACTION REQUESTED: _____

AWARE OF REFERRAL: CLIENT: *yes / no* PARENT / CARER: *yes / no*

FAMILY DETAILS:

PARENT / CARER'S NAME: _____ PARENT / CARER'S NAME: _____

D.O.B: _____ D.O.B: _____

INCOME SOURCE: _____ INCOME SOURCE: _____

FAMILY MAKE UP: _____

OTHER SIGNIFICANT PERSON'S: _____

REFERRAL FROM: _____ REFERRAL TO: _____

OTHER AGENCIES/SERVICES INVOLVED: _____

SCHOOL ATTENDED: _____ STILL ENROLLED: *yes / no*

ANY SAFETY ISSUES: _____

