Youth Support Services (YSS) Referral Form

Please forward referrals to yss@masp.org.au

Has the young person or family provided consent for a referral to the YSS Program? YES NO

If no, why not?

Referrer details

Name:	
Organisation:	
Position:	
Contact details:	

Client Information

Full Name:	
Preferred name (optional):	
Date of Birth:	
School Year Level:	
Gender:	
LGBTQIA+	
Address:	
Cultural Identity:	
Language at home:	

Is an interpreter required?	
Mobile number:	
Email:	

Is the young person consenting to participate and voluntarily engage in the YSS Program?	**YES**	**NO**
Is the young person a client of Child Protection or Youth Justice? If so, who is the case worker?	**YES**	**NO**
Is the young person subject to a deferral sentence or supervised bail?	**YES**	**NO**
Date of most recent contact with police: If this is not the first contact, date of first contact: Brief details of the circumstances (optional):		

Members of Household / Family / Extended family

Name	M/F	DOB	Age	Relationship to Primary Caregiver	Residing with client Y/N

Other supports involved

Agency	Previous or Current	Relationship/Role (specify which family member engaged with)	Contact Person & Details

Further information

Reason for referral and presenting concerns:
Details about the family's background, including any strengths and potential risks:
Other relevant information, including AOD use, education, community involvement, mental health:
What does the young person want to achieve during the YSS intervention: