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| NAAJA THROUGHCARE REFERRAL FORMreferrals-throughcare@naaja.org.au |
| **FAMILY NAME:** | **GIVEN NAME:** |
| **GENDER:** [ ]  Male [ ]  Female **IJIS No.:** | **DATE OF BIRTH:** [ ]  Adult [ ]  Youth |
| **IS THE CLIENT IN CUSTODY?** [ ]  Yes [ ]  No**STATUS:** [ ]  Sentenced [ ]  Remanded **(youth only)** [ ]  Supported bail accommodation **(youth only)** | **LOCATION OF CLIENT:** [ ]  Alice Springs [ ]  Darwin [ ]  Other If other please specify location:  |
| **RELEASE INFORMATION:** |
| **NPP (NON PAROLE PERIOD):** [ ]  Yes [ ]  No [ ]  Passed**NPP DATE:** | **FULLTERM DATE:****RELEASE DATE (IF CONFIRMED):****NEXT COURT DATE (YOUTH ONLY):** |
| **DOCUMENTATION (PLEASE ATTACH COPIES):**  |
| **THROUGHCARE IS A STRENGTHS BASED VOLUNTARY PROGRAM AND THEREFORE CANNOT BE MADE A CONDITION OF AN ORDER**Is client aware of referral? **[ ]  YES [ ]  NO**If yes, please attach a copy of the client’s Authority for Release of Information and provide copies of any of the following orders:**[ ]  ANTECEDENTS [ ]  PRECIS [ ]  PAROLE [ ]  SUSPENDED SENTENCE (PROBATION) [ ]  ANCOR [ ]  DVO****[ ]  OTHER (please specify below)** |
| **OTHER SERVICES ENGAGED WITH CLIENT (PLEASE PROVIDE CONTACT NAMES AND NUMBERS):** |
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| **WHAT ARE THE CLIENT’S HIGH NEEDS? (ie HOMELESSNESS, LITERACY NUMERACY ISSUES, FAMILY VIOLENCE ETC)** |
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| **ADDITIONAL INFORMATION:** |
| What assistance would you like your client to receive from Throughcare?**NAME: DATE OF REFERRAL:****REFERRING AGENCY:** |
| **THROUGHCARE OFFICE USE:** |
| **ALLOCATED TO:**[ ]  BRIEF INTERVENTION[ ]  CASEWORK**DATE OF ASSESSMENT:** | [ ]  DECLINED ASSISTANCE[ ]  OUTSIDE CRITERIA (SPECIFY) | **DATE OF ALLOCATION:**[ ]  REFERRED (SPECIFY)**SIGNATURE:** |  |