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| NAAJA THROUGHCARE REFERRAL FORM referrals-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:** |  |