**Worker:**

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| **CLIENT DETAILS** |
| **Name:****Gender:****ID:** |  | **Date of Birth/** **Age:** |  |
| **Country of Birth:** |  | **Main Language:** |  |
| **Indigenous Status:** |  | **Mobile phone:** |  |
| **LEGAL** |
| **Are you currently involved with the police / Corrections / courts? Details.****Is the person or are you under a Protection Order? DVO? No Contact Order?****Please provide Copies of Protection Orders or DVO’s****Are you involved in any restraining orders (either by you or against you)? Details.****Are you involved with TF / Guardianship / Family Courts?** |
| **OTHER** |
| Is there anything else you would like us to know in order for ASYASS to better support you? |
|  |
| **SUPPORT PERIOD** |
| **Date in :** | **1st period:** | **2nd period:** | **Referred by:****Contact Number:****Referring Agency:** |
| **Reasons for seeking assistance:****If Bail Support Please provide Bail Conditions, Current Charges and Court Dates if known.** | Do you know what ASYASS does? |
| How long do you think you might need to stay? | What assistance do you need?  |
| **Who were you living with before you came to the coming to ASYASS? Details:** |
| **Name:** | **Address:** | **Relationship:** |
| **Type of housing and tenure (eg. rental, public)?** | **Phone:** | **How long had you stayed there?****Reason for leaving:** |
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| **HEALTH / LIFESTYLE** |
| Do you have any diet / nutrition needs? | Do you have any allergies orhave a disability? |
| Any health problems? Medication? that you want to tell us  | Do you have a Medicare Card or Health Care card? |
| How are you feeling? | Diagnosed with any mental health issues? |
| Do you use any alcohol or other drugs? Any problems?  | Do you have any anger management issues? Can you describe |
| Have you ever harmed yourself/ or had self harm thoughts? | Have you ever harmed anyone else? |

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| **PEOPLE YOU CARE ABOUT** |
| Name/s: | Relationship: | Address: | Phone: |
| When did you first leave home? | Any concerns about ASYASS contacting family in case of an emergency? :  |
| Are you receiving help / support from another agency / service?Contact person/ Phone: |

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| **HOUSING**  **(2nd Period please add any new details if they have changed)** |
| Is returning to stay with family an option? Where would you like to be staying?Where could stay if you were asked to leave the ref?(Other family members or friends you could stay with?) |

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| **EDUCATION / INCOME SUPPORT / EMPLOYMENT** **(2nd Period please add any new details if they have changed)** |
| **Are you currently going to school / training? Details**.  |
| **Are you receiving an income?** If no, who is supporting you? eg money for food, clothes etc**Details:** **Are you working?** Details: |

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| **SUPPORT WORKER REFERRING YOUNG PERSON** |
| How are you involved with the young person? Contact details and continued involvement?**2nd Period:**  |
| What circumstances precipitated you bringing the young person to us?**2nd Period:**  |
| Important information pertaining to the young person?**2nd Period:**  |
| **END OF SUPPORT PERIOD** |
| **1st Period** Date out: | Date Out - **2nd Period:** |
| Reason for leaving: |  |
| Forwarding contact details (phone / address): |  |
| Young person’s belongings: |  |
| Main outcomes from Support Period: |  |
| Follow up plan: Agreed to by young person? □ Yes □ No | Follow up plan: Agreed to by young person? □ Yes □ No |
| Support Period entered & closed off on SHIP □ Yes | Support Period entered & closed off on SHIP □ Yes |

Summary of Risk ((from 1 being no risk to 5 high risk)

Have you completed the Risk Assessment?

Does the Client pose a Risk to others? Yes No, if yes Level of Risk \_\_\_\_\_\_\_\_

Does the Client Pose a Risk to Themselves? Yes No, if Yes Level of Risk \_\_\_\_\_\_\_\_\_\_\_\_\_

Does the Client have Ongoing Mental Health Issues? Yes No, if Yes Level of Risk \_\_\_\_\_\_\_\_\_\_\_\_ Managed? Yes No

 (How?)

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Does the Client have Ongoing Domestic or Family Violence Issues? Yes No , If Yes Level of Risk\_\_\_\_\_\_\_\_\_\_

If Yes, are they the victims or the purptrators or both?\_\_\_\_\_\_\_\_\_\_\_\_

Any other health issues? (ie: pregnancy? Disability? FASD?)

Total Risk? \_\_\_\_\_\_\_\_\_\_

Have you attached the Client Consent Form? Yes No, if No why not?\_\_\_\_\_\_\_\_\_\_\_\_

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Client Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ Accepted? Yes No

Staff Signature Date

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Supervisor Signature Date