# Referral Form
# SPAYC+

| Date of Referral: / / | | Date of Review: / / |
|---|---|---|

## Participant Details

| Family Name | | Given Name/s | | | | | |
|---|---|---|---|---|---|---|---|
| Date of Birth | | Age | | Gender | | M | F |
| Address | | | | | | | |
| Home Phone | | Mobile | | Email | | | |

| Cultural background | ☐ Aboriginal ☐ Torres Strait Islander ☐ Other: ____________________<br>☐ Non- English Language (s) spoken in home ___________________________<br>☐ English; Please scale (barely speak 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ understand and speak well)<br>☐ Home Country_______________ |
|---|---|

### Questions about the participant

Education level attainment:

Yr. Level*(please select)*: ☐ Completed Primary 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ Tertiary ☐

If the participant did not complete Yr. 12, please give reason why:

In the past 4 weeks, has the participant undertaken any social well-being activities?

☐ Yes ☐ No

If no, why: ___________________________________________________________________________

If so, what: ___________________________________________________________________________

How 'connected' is the participant to his/her your family?

☐ 1(not very) ☐ 2 ☐ 3 ☐ 4 ☐ 5 (very)

Does the participant feel included in his/her community?

☐ 1(not very) ☐ 2 ☐ 3 ☐ 4 ☐ 5 (very)

## Consent Information

SPAYC+ Project is an extension of the Space and Place Activities for Youth in Cairns (SPAYC) project, which aims to increase the availability and choice of structured diversionary activity for young people aged 13 to 25-years old who are disengaged or at-risk of disengagement from education, employment or community, are in touch with or at risk of entering the young or criminal justice system, engaging in unhealthy and anti-social behaviours, or socially disadvantaged, and diverting them to positive pro-social activities and linking them to appropriate supports.

By partnering with funded services and government agencies, SPAYC+ will deliver diversionary, interventional and engagement activities. SPAYC+ will work with various government and non-government agencies, delivering diversionary, interventional and engagement activities to SPAYC+ participants.

## Referral Agency Details

| **Agency** | | **Contact Person** | |
|---|---|---|---|
| **Address** | | **Contact Number** | |
| **Email** | | | |

| **Home Phone** | | **Mobile** | | **Email** | |
|---|---|---|---|---|---|

## Referral Reason *(select where appropriate)*

☐ Social connectedness
- *connection to community*
- *connection to family*

☐ Emotional Connectedness
- *self esteem*
- *self confidence*

☐ Physical Well-Being
- *self-identity*
- *hygiene*

☐ Mentoring & Leadership
- *program support/participation*
- *individual / group*

☐ Mental well-being
- *peer network support*

*Current Agency Involvement*_______________
*(concerns identified)*

☐ Other(please specify):

_______________________________

_______________________________

## Current Support Plan - to be completed by Referral Agency

Start date:___/____/____

<table>
<tr><td>Emergency Contact: Name: Please list English Speaking Contact</td><td></td><td rowspan="2">Emergency Contact Phone Number/s:</td><td rowspan="2"></td></tr>
<tr><td>Relationship to participant:</td><td></td></tr>
<tr><td>Any Existing Medical Conditions:</td><td colspan="3">Yes / No If yes, please provide participant name and details:</td></tr>
<tr><td>Are you taking any regular medication:</td><td colspan="3">Yes / No If yes, please provide participant name and details:</td></tr>
</table>

<table>
<tr><td colspan="2">Participation Agreement & Consent</td></tr>
<tr><td>☐</td><td>I acknowledge that all activities attended may contain an element of risk and must take reasonable care whilst participating in activities. It is the responsibility of participants to engage in activities that he/she has the capacity, interest and willingness to comply with safety measures. Failure to comply with safety instructions including disrespectful behaviour towards others may result in exclusion from the activity.</td></tr>
<tr><td>☐</td><td>In the event of accident or illness, I authorise the Activity Provider to obtain or administer medical assistance or treatment reasonably required which may be prescribed by an appropriately qualified medical practitioner. I acknowledge that any such treatment, including evacuation and transport shall be my sole responsibility</td></tr>
<tr><td>☐</td><td>I have provided the details of emergency contact and give my consent to contact the listed persons in the event of accident or illness</td></tr>
<tr><td>☐</td><td>I give permission to use photographs/videos for marketing and promotional purposes or for use in media stories/advertising/publications relating to the FIT Together program, without financial recompense in the form of royalties or similar payments</td></tr>
<tr><td>☐</td><td>As the Parent/Guardian of the above named person/s I give full permission for my child to participate in any activities or programs under the SPAYC+ program.</td></tr>
<tr><td>☐</td><td>As the Parent/Guardian of the above named person/s I consent to my child travelling in approved / registered / licensed vehicles</td></tr>
<tr><td>☐</td><td>I give permission to the provider and/or Safer Streets to refer my family to access further support services.</td></tr>
</table>

<table>
<tr><td>Name:</td><td colspan="3"></td></tr>
<tr><td>Signature:<br>If participant is under 18 years, signature of Parent or Guardian</td><td></td><td>Date:</td><td></td></tr>
<tr><td colspan="4">OFFICE USE ONLY</td></tr>
<tr><td>CONFIRMED WITH PARENT / GUARDIAN</td><td>VERIFIED BY (NAME OF OPERATOR):</td><td>DATE:</td><td>TIME:</td></tr>
</table>

Please return via email:
Attention: SPAYC+ Referral
Cairns.SaferStreets@police.qld.gov.au