Wesley Kids Referral Form

email: wesleykidsgc@wmq.org.au
Phone: 07 5625 1901

Referrer Details:	
Referrer name:	Referral Date:
Referrer Organisation:	Referrer Role:
Referrer Email:	Referrer Phone:
Reason for referral:	

- ❑ Client has been informed about and consented to information on this referral form being shared with Wesley Mission Queensland and other service providers involved in their care.
- ❑ Client has given consent to be contacted by Wesley Kids.

Parent/Guardian Details	
Full Name:	Relationship to child:
Street Address:	Postcode:
Phone Number:	Is it OK to leave a message? ☐Yes ☐No
Email Address:	
Country of Birth ☐Australia ☐Other: _____	Ethnicity: ☐Australian ☐Aboriginal ☐Torres Strait Islander ☐ Aboriginal & Torres Strait Islander ☐Other _____
Employment Status: ☐Self-employed ☐Full-time employment ☐Part-time casual ☐Not in the workforce ☐Receives Centrelink benefit	Gender: ☐Female ☐Male ☐Transgender ☐Non-binary ☐Other _____
Marital Status: ☐Single ☐Married/de facto ☐Divorced/Separated ☐Other _____	If separated, does the other parent agree to the child/ren attending Wesley Kids? ☐Yes ☐No

Child Details:	
Full Name:	Preferred name:
Street Address: ☐Same as parent	School:
Date of Birth:	Country of Birth ☐Australia ☐Other:_____
Gender: ☐Female ☐Male ☐Transgender ☐Non-binary ☐Other _____	Ethnicity: ☐Australian ☐Aboriginal ☐Torres Strait Islander ☐ Aboriginal & Torres Strait Islander ☐Other _____
GP Mental Health Treatment Plan Developed? ☐Yes ☐No ☐In process of development GP: _____	
Sibling #1 Name & Age:	
Sibling #2 Name & Age:	
Sibling #3 Name & Age:	

Child-related concerns	
☐ Child behaviour ☐ Parental separation/divorce ☐ Grief and loss ☐ Parental substance abuse/addiction ☐ Child trauma ☐ Self-harm or suicidal ideation ☐ Domestic and family violence ☐ Child abuse or neglect ☐ Child Safety involvement ☐ Child developmental concerns	Has a referral been made to CYMHS/Acute mental health care team? ☐Yes ☐No Is the child/family currently working with other support services? If yes, please list: _____ _____ _____
Is there anything else you think we should know about that may impact upon your client's ability to participate in Wesley Kids Programs? _____ _____ _____ _____ _____	
Please select what services the child is being referred for: ☐ Individual therapy ☐ Grief and loss program ☐ Anxiety programs ☐ Parenting support	