**Email referral to:** eksnreferrals.wa@keyassets.org.au **Phone:** 1300 318 789

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| **ELIGIBILITY CRITERIA (cross applicable box)** | |
| Person is caring for a child or young person and are seeking help in accessing support services (excluding children who are open to, or in the care of Child Protection) |  |
| A young person aged 18-25 years who is seeking help in accessing support services (with priority given to those who have had an experience of living in out-of-home care) |  |
| A mature minor who is 16–17 years old and is living independently (excluding young people who are open to, or in the care of Child Protection) |  |

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| **Referrer details** | | | | | |
| Department of Communities  Other organisation  Self  Other (specify) | | | | | |
| Date of referral |  | | | | |
| Referrer’s name and organisation |  | | | | |
| Referrers contact telephone | Work |  | | Mobile |  |
| Referrers email |  | | | | |
| Family/ Young Person is aware and consents to this referral (required) | | | Yes / No | | |

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| **Client details** | | | |
| 1. Client name |  | D.O.B |  |
| 1. Ethnicity | Aboriginal  TSI  CALD  Other (specify) | | |
| 2. Client name |  | D.O.B |  |
| 2. Ethnicity | Aboriginal  TSI  CALD  Other (specify) | | |
| Address |  | | |
| Telephone |  | | |
| Email |  | | |
| **Children** | | | |
| 1. Name & gender |  | D.O.B |  |
| 2. Name & gender |  | D.O.B |  |
| 3. Name & gender |  | D.O.B |  |
| 4. Name & gender |  | D.O.B |  |

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| **Reason for referral** |
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| **OUTCOME OF REFERRAL (to be completed by EDSN)** |
| Accepted  Declined  Date: |
| If declined, reason for declining referral: |
| Client/s notified of outcome: Y  N  Referrer notified of outcome: Y  N |