**DATE:** Click here to enter text.

**CLIENT DETAILS**

**Full Legal Name:** Click here to enter text.

**Full Residential Address:** Click here to enter text.

**Contact Phone Number:** Click here to enter text.

**Email Address:** Click here to enter text.

**Date of Birth (D.O.B.):** Click here to enter text.

**Marital Status:** Click here to enter text.

**Background:** Aboriginal  Torres Strait Islander  LGBTIQA+  Other

**Other, please specify:** Click here to enter text.

**Comments (Optional):** Click here to enter text.

**EMERGENCY CONTACT DETAILS FOR CLIENT (If Available)**

**Emergency Contact Name:** Click here to enter text.

**Relation:** Click here to enter text.

**Contact Phone Number:** Click here to enter text.

**Contact Email Address:** Click here to enter text.

**State of Residency:** Click here to enter text.

**Comments (Optional):** Click here to enter text.

**Clients Presenting Issues or Concerns:** Click here to enter text.

**Assessment Outcome:** Click here to enter text.

**Any Specific Program for Referral:** Click here to enter text.

**Any Special Requirements or Considerations:** Click here to enter text.

**Comments (Optional):** Click here to enter text.

**What eligibility criteria do you wish for us to assess the client under for the Community Justice Program/WDP?**

|  |  |
| --- | --- |
|  | Have a significant mental or intellectual disability, disorder, or illness |
|  | Have an addiction to drugs, alcohol; or a volatile substance |
|  | Experiencing homelessness |
|  | Experiencing acute financial hardship |
|  | Victim of family or domestic violence |

**Other, please specify:** Click here to enter text.

**Types of activities you are willing to undertake for your WDP, once approved by the WDP administration:**

|  |  |
| --- | --- |
|  | Unpaid work |
|  | Courses – including educational, vocational or life skills courses |
|  | Counselling, including financial and other counselling (excluding drug and alcohol counselling) |
|  | Drug or alcohol counselling |
|  | Mentoring for people under 25 years of age |
|  | Treatment given by an accredited health practitioner |

**Other, please specify:** Click here to enter text.

**REFERRAL OUT DETAILS**

**Referral Agency Name:** Click here to enter text. | **Name of Agency Worker:** Click here to enter text.

**Contact Email Address:** Click here to enter text. | **Contact Number:** Click here to enter text.

**Reason for Referral:** Click here to enter text. | **Additional Comments** (optional)**:** Click here to enter text.