Yakapna Healing Centre
Njernda Aboriginal Corporation

Client Assessment & Information

Referrals

In order for this referral to be assessed:

- All sections must be completed.
- All information provided must be true and correct
- Referrals must comply with privacy requirements.

Acceptance will also depend on the client agreeing to the Rights and Responsibilities and program guidelines associated with this Njernda Aboriginal Corporation service which protect the safety & welfare of clients and staff.

Failure to comply will result in non-acceptance of this referral

On completion, return referral by fax or email (consideration should be given to privacy and confidentiality of documents you send via email) to:

Name: ***Simone Ronnan***

Position: ***Yakapna Manager***

Service: ***Njernda Aboriginal Corporation***

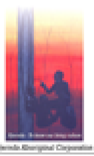
Fax: ***(03) 5480 2250***

E-mail: simoner@Njernda.com.au

Phone: ***(03) 54807847***

This referral is not an indication of acceptance into our service.

Formal advice of acceptance/rejection of this referral will be provided as soon as possible.



NJERNDA ABORIGINAL CORPORATION

84 Hare Street, Echuca Vic 3564 **ABN:** 17 334 858 388
Phone: (03) 5480 6252 **Fax:** (03) 5480 2250
Web: www.njernda.com.au

YAKAPANA REFERRAL FORM

THIS REFERRAL IS REQUIRED TO BE COMPLETED FULLY, IF THIS REFERRAL IS NOT COMPLETE IT WILL BE RETURNED OR REJECTED

To be completed by the Person making Referral/Referring Agency

CLIENTS DETAILS

Clients Name (1)			
Date of Birth		**Telephone No.**	
Clients current address			
Culture	☐Aboriginal ☐Torres Strait Islander ☐Both ☐Other COMPLETE ATTACHED ABORIGINALITY DOCUMENT (MANDATORY)		
Healthcare / Centrelink No		**Centrelink payment type**	
Medicare Card Number & Ref No.		**Expiry Date**	
Next of Kin		**Address/Phone**	

Clients Name (2)			
Date of Birth		**Telephone No.**	
Clients current address			
Culture	☐Aboriginal ☐Torres Strait Islander ☐Both ☐Other COMPLETE ATTACHED ABORIGINALITY DOCUMENT (MANDATORY)		
Healthcare / Centrelink No		**Centrelink payment type**	
Medicare Card Number & Ref No.		**Expiry Date**	
Next of Kin		**Address/Phone**	

CHILDREN			
Name	Date of Birth	Age	Sex M / F

Are there other children staying elsewhere? If so where are they staying (include contact details)?

____

____

What is the most important relationship in the Client's life at this time?
(E.g. parent, partner, sibling, child) Please list and advise whether these are currently supportive or difficult relationships at this time?

Background Information: - Other

DETAILS OF PERSON MAKING REFERRAL TO YAKAPNA

Name of Person making Referral:			
Position:			
Organisation			
Address			
Phone Number		Fax	
Mobile Number		Email	

As the person making the referral to Yakapna; you are automatically designated as the Client's Case Worker and required to:

- Transport the Client to Yakapna;
- Participate in Case Planning and Exit Planning Meetings;
- Make weekly phone calls to the Client and Yakapna Co-ordinator, as ongoing support to the Client, and the Program.

Provide support to the Client during their Post Program Support Phase.

WHAT OTHER SERVICES ARE CURRENTLY INVOLVED WITH THE CLIENT?

Please provide the name, service and phone number:

	Name	Service	Phone Number
1			
2			
3			
4			
5			
6			
7			

1. Why have you referred the client/s to Yakapna?	
• Is this a self-Referral	Yes / No
• Has the client/s been court ordered	Yes / No
• Is the client under any DOCS/DHS Orders If yes please attach order/s	Yes / No
Other Information:	

2. Does the client have any other legal issues pending?	Yes / No
Has the client/s been court ordered	
If YES, what are they?	

3. Have you explained the requirements of Yakapna to the client	Yes / No

Who would the client like to have involved in discussions while at Yakapna? **Please provide name, organisation and contact details.**

4. Have you explained the requirements of Yakapna to the client?	Yes / No

5. Has the client agreed to this referral?	Yes / No

6. What does the Client aim to achieve, during their stay at Yakapna? Please describe.

7. Does the client/s use any substances? Yes / No
(If Yes, provide details indicating which client it refers to e.g. client 1, 2, or both)

Description	Current Use	Past Use	Years, Months	How much/often
Alcohol				
Amphetamines				
Cannabis				
Cocaine				
Ecstasy				
Heroin				
L.S.D				
Methadone				
Amphetamines				
Cannabis				
Cocaine				
Ecstasy				
Heroin				
L.S.D				
Methadone				
Tobacco				
Coffee				
Prescribed Medication Misuse				
Other/inadequately described Analgesics				
Inhalants eg.petrol				

HEALTH DETAILS

Doctors Name	
Name of Medical Clinic	
Address	
Telephone number	
Fax Number	
Client Allergies – Please list individual allergies for each client.	Name:
	Name:
	Name:
	Name:

8. Is the Client currently taking medication of any sort?	Yes / No
If yes, please list all medications and what they are used for and/or ensure that their Medical Assessment includes information about medication currently being taken. Please specify individuals name.	

9. Has the Client attended a Medical Assessment with a local GP?	Yes / No
If yes (it is mandatory to provide information below) If no, this can be arranged by Yakapna **a.** Please attach a copy of this report to this Referral Form. **b.** Please ensure that a list of medications has been provided. **c.** Please ensure that follow up treatment dates etc have been provided. **d.** Please ensure that necessary medications and Medical Referral letter has been provided from the Client's doctor, to the Njernda Aboriginal Corporation Doctors.	

10. Has the Client ever attended a Rehabilitation Centre as a residential or day program client before?	Yes / No
If Yes, where and when:	

11. MENTAL HEALTH	
Does the Client have any Mental Health conditions	Yes / No
If yes, when was the last mental health plan undertaken? (date)	
If yes, what is the condition/s and are they currently being addressed?	
Does the client have a current Mental Health Case Manager/Support Worker and who is it?	
Has the Client attended a Psychiatric Assessment? (If yes, attach a copy)	Yes / No
Does the Client have a history of Self Harm? (If yes, provide details)	Yes / No
Is the client currently self-harming? (explain)	Yes / No
Has the Client been provided with education and support around strategies for dealing with their Self Harming issues?	Yes / No
Are their currently any distressing issues going on in the Client's life at this time that may be leading to their self harm tendencies? E.g. relationship issues, family conflict? Please explain.	Yes / No
Is the Client suicidal at this time?	Yes / No

12. ANGER MANAGEMENT	
Does the Client have a background of violence or anger? If yes, explain	Yes / No
Is this still an issue, at this time? Please describe.	
Has the Client been provided with education and support around strategies for dealing with their violence and anger issues?	Yes / No
How might we be able to assist the Client to deal with these issues while they are at Yakapna?	
Is the Client a COATS client? If so, please provide their contact person at COATS? Including phone number & position.	Yes / No
Are there any other details that you or the Client, feel we must know to be able to care for them effective and appropriately?	

ACCOMMODATION

Current:

Stable ☐ Unstable ☐ Short term ☐ Long term ☐ Homeless ☐

At risk of Homelessness ☐ Public Housing ☐ Rental ☐ Buying ☐

Own ☐

Comments:____

History of Public Housing:____

Who does client/ Family live with: ____

Njernda Aboriginal Corporation

CONFIRMATION OF ABORIGINALITY

Applicant Declaration

NAME:________________________ SURNAME:________________________

OTHER NAMES (eg: maiden, nicknames)________________________

RESIDENTIAL ADDRESS:________________________

____

D.O.B.________________________ PLACE OF BIRTH:________________________

MOTHERS MAIDEN NAME:________________________ GIVEN NAMES:________________________

FATHERS NAME:________________________ GIVEN NAMES:________________________

NAME OF TRIBAL, CLAN OR FAMILY GROUP (IF KNOWN)________________________

AMOUNT OF TIME LIVING IN THIS REGION (ECHUCA & DISTRICT)________________________

I hereby declare that I am of Aboriginal descent, I identify as an Aboriginal and I am accepted as such by the community in which I live.

________________________ ________________________

Signature of Applicant and/or
Signature of Parent/Guardian
(if applicant is under 15yrs of age)

Date

Declared at:________________________ this________________________

Day of:________________________ year________________________

This section is to be completed by Njernda Aboriginal Corporation.

It is hereby confirmed that the above named is of Aboriginal Descent, identifies as an Aboriginal and is accepted as such by the community in which they live.

Meeting Date:________________________

Seconded By:________________________ ________________________
(Board of Director) (sign name)

Seconded By:________________________ ________________________
(Board of Director) (sign name)

(Njernda Aboriginal Corporation common Seal to be stamped above)

SUPPORTING DOCUMENTS

- ☐ **Confirmation of Aboriginality**
- ☐ **Medical Assessment**
- ☐ **Psychiatric/Mental Health Assessment**
- ☐ **DOCS/DHS Orders**
- ☐ **Court Orders**
- ☐ **Other attachments – please list:**

Has the client consented to the release of this information to our service? Yes / No
Please provide a copy of signed consent.

All information provided in this document is true and correct, at the time of the Referral being made to Yakapna.

Case Worker's Name:____

Case Worker's Signature:____

Case Worker's Mobile Phone Number:__________________________________