Specialist Therapy Services
Rockhampton & Gladstone
Referral Form

ROCKHAMPTON
referralsrockysva@actforkids.com.au
(07) 4860 8100
38 Armstrong Street Rockhampton 4701

GLADSTONE
referralsgladysva@actforkids.com.au
(07) 4910 8810
30 Glenlyon Street Gladstone Central 4680

Act for Kids Specialist Therapy Services is a free therapeutic service that adapts evidence-based interventions to respond to children and young people who have been impacted by unwanted sexual experiences, or those who display harmful sexual behaviours. Our services are tailored to meet the individual needs of children, young people and their families in Rockhampton and Gladstone.

Please complete all sections of the referral form.
Your referral may not be accepted if relevant information is not provided.
Please provide completed referral forms electronically via email, to the relevant office location above.
Your referral will be formally acknowledged and you will be contacted by the service.

CHILD/YOUNG PERSON BEING REFERRED *If more than one child please complete additional forms.*		
First name:	Last name:	
D.O.B:	Gender:	Phone:
Current living situation: ☐ Home ☐ Residential Care ☐ Out-of-Home Care ☐ Other *(provide details)*: Additional Information (*e.g. length of time in care/out of home*):		
Address:		
☐ Aboriginal	☐ Torres Strait Islander	☐ LGBTIQA+
Ethnicity: Australian		
Languages Spoken: Interpreter required: ☐ Yes ☐ No		
School/Centre:		
School contact person:		

CHILD'S PRIMARY PARENT/CAREGIVER DETAILS *Psychoeducation will be provided regarding sexual abuse/harmful behaviours. Please consider attaching a genogram of child/young person's family.*	
First Name:	Last name:
Relationship to child:	Phone:
Address *(if different to child)*:	
Email:	
Time child/young person spends with Parent/Caregiver:	

Are there any Court Orders relating to this child? ☐ Yes ☐ No If yes, details of Order *(e.g. Family Law, Child Protection, Youth Justice, Mental Health, DFV, Forensic)*:

ADDITIONAL PARENT/CAREGIVER DETAILS	
First Name:	Last name:
Relationship to child:	Phone:
Address:	
Email:	
Time child/young person spends with Parent/Caregiver:	

REFERRER DETAILS	
Name:	Position/Relationship to child:
Organisation (if applicable):	
Address:	Email address:
Phone:	Preferred contact method:
Referral discussed with, and agreed by Parent(s)/Carer(s): ☐ Yes ☐ No	
Does the child/young person understand the reason for referral: ☐ Yes ☐ No	
Date of referral:	

REFERRAL INFORMATION
Service location: ☐ Rockhampton ☐ Gladstone
Child/young person is aged 18 years or under and: ☐ Experienced sexual harm ☐ Exposed to, or at risk, of sexual harm
Child/young person is aged 10-17 years and: ☐ Reacting with harmful sexual behaviours
Is there current Police and/or Youth Justice Involvement? ☐ Yes ☐ No If yes, please describe the intervention or investigation: ***Please record the Police or Youth Justice Officer's name and contact details in 'engagement with other services' section below.***
Is the child/young person involved with Child Safety? ☐ Yes ☐ No If yes, is there an Order? ☐ Yes ☐ No Details of Order *(e.g. IPA, STC, LTG - CE, LTG - SO, unknown)*:
Who has legal responsibility for the child/young person? Please provide contact details if not the primary caregiver *(as listed above)*:

CHILD/YOUNG PERSON RELATED CONCERNS:

☐ Behavioural Concerns
☐ Psychiatric Diagnosis
☐ Learning Difficulties
☐ Trauma Concerns
☐ Developmental Issues
☐ Medication
☐ Interpersonal Relationship Concerns
☐ Other Concern/s
☐ Engaging in Reactive/Harmful Sexual Behaviours to self-and/or others

Please provide details:

REASON/S FOR REFERRAL – Please provide as much information as possible

Please be mindful of the privacy of others when completing this field.

Behaviour of concern: *(sexual/emotional/risky; triggers/persistence/frequency/touching moments/location/consent issues/age of child harmed; who has the behaviour impacted (e.g. peers/siblings); family's response to behaviour; is there risk of further concerning behaviours occurring?)*

Background information: *(key life events; attachments)*

Previous/current engagement with other services: *(please include contact information, and any relevant assessment information should be attached)*

Thank you for your referral.

Please email completed referral form to the relevant office location as listed above.

Contact will be made with you using your nominated details once the referral has been processed.