THE PARKS COMMUNITY NETWORK INC
ABN 21 309 587 346
Community Service Centre, Stockland Mall
561-583 Polding Street, Wetherill Park
PO Box 3147, Wetherill Park NSW 2164
Phone: (02) 9609 7400
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TEI Family Support Service
Referral Form

The family support service cannot commence until this form has been completed in full and received by the Family Support Service Coordinator (fsscoordinator@parkscommunity.org.au).

All information will be treated in the strictest confidence.

Please print clearly **Date of referral:**

1. Referrer / Agency Details

Agency:_____

Referrer's Name:_____ Position:_____

Telephone:_____ Postcode:_____

Mobile:_____ Fax:_____

E-mail:_____

2. Parent/Carer Information

Title: Miss / Mrs. / Ms / Mr. Full name: _____

Preferred to be called:_____

Address:_____

Suburb:_____State:_____Postcode:_____Gender: ☐Female ☐Male

Date of birth:_____/ _/_____Country of birth:_____Ethnicity:_____

Home Number:_____Mobile Number:_____Work Number:_____

Language spoken at home:_____ Visa Status:_____

Is language / communication assistance required: ☐ Yes ☐ No
Specify:_____

Emergency Contact Name: _____ **Phone Number:** _____

Indigenous Status: ☐ Aboriginal ☐ Torres Strait Is.
☐ Both Aboriginal & Torres Is. ☐ Non-Indigenous

Authorisation & Consent: Is client aware of referral? ☐ Yes ☐No

Consent type: ☐ Verbal ☐ Written Date & time of consent: _____

3. Other services involvement

Is there an allocated case worker? _____

Name of case worker _____

Which office is the case held at?_____

Ph. no. _____

4. C

Name of Child	Surname of Child	Date of Birth / Age	Male/Female	Address (if different)
1			☐Female ☐Male	
2			☐Female ☐Male	
3			☐Female ☐Male	
4			☐Female ☐Male	
5			☐Female ☐Male	
6			☐Female ☐Male	

5. Health

What is the client and or child/ren's medical history? Do they have any illness, allergy, physical disability, special needs or medical requirement? Do they have a learning disability or mental health needs? Please give details:

_____

_____

_____

_____

6. Safety / Supervision Issues

In relation to any family members, is there any history of:

Self harming? ☐ Yes ☐ No

What form does this take?

_____

_____

_____

Substance misuse? ☐ Yes ☐ No

What substances and in what context?

_____

_____

_____

Violence? ☐ Yes ☐ No

AVO? ☐ Past. What year did it expire? _____ ☐ Current. Year to Expire:_____ ☐ Never ☐ Unknown

To whom and in what context?

_____

_____

_____

Other? (Including gambling harm) ☐ Yes ☐ No

_____

_____

_____

7. Reason for Referral / Support Task

Please give details of why the referral is being made:_____

_____

_____

_____

What is the anticipated length of support and action required?_____

_____

_____

_____

How urgently is support required?_____

_____

_____

_____

Start Date:_____/_____/_____

What are the desired outcomes?_____

_____

_____

_____

8. Identified family concerns/problems

Priority 1

- Physical abuse
- Sexual abuse
- Emotional abuse
- Domestic violence
- Homelessness
- Grief, loss and/or separation
- Infant management
- Neglec:. Type/s _____

Priority 2

- Substance abuse – parent / child
- Psychiatric issues – parent / child
- Removal of children
- Diagnosed post-natal depression

Priority 3

- Inadequate family/community support
- Parenting difficulties
- School difficulties
- Child's behavioral problems
- Home management
- Housing issues
- Obtaining custody of children
- Disability – parent / child
- Financial issues
- Other _____

  _____

  _____

Please attach: any other information that may be useful for the family support team.

Signed:_____Print:_____Date:_____/___/_____

_____

_____

OFFICE USE ONLY

Referral Assessment Outcome:

Staff signature:_____Staff signature:_____