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
Fax: (02) 9757 1094

The Family Support Service's 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:**

1. Referrer / Agency Details

Agency:_____

Referrer's Name:_____ Position:_____

Telephone:_____ Postcode:_____

Mobile:_____ Fax:_____

E-mail:_____

2. Client 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:_____

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

To whom and in what context?

_____

_____

_____

Other? ☐ 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
- Neglect

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
- 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:_____