

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. 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: _____

Next of Kin: _____

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. Client Family Structure

Name of Child	Surname of Child	Date of Birth	Male/Female	Address (if different)
1			<input type="checkbox"/> Female <input type="checkbox"/> Male	
2			<input type="checkbox"/> Female <input type="checkbox"/> Male	
3			<input type="checkbox"/> Female <input type="checkbox"/> Male	
4			<input type="checkbox"/> Female <input type="checkbox"/> Male	
5			<input type="checkbox"/> Female <input type="checkbox"/> Male	
6			<input type="checkbox"/> Female <input type="checkbox"/> 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: _____