

**FLEURIEU FAMILIES – REFERRAL FORM**

**Email:** [**fleurieufamilies@victor.sa.gov.au**](mailto:fleurieufamilies@victor.sa.gov.au)

* **This form is for referral to Fleurieu Families for parents with children 0-18 years of age residing in council districts of Victor Harbor, Yankalilla and Coastal Alexandrina**
* **IMPORTANT! All referrals to Fleurieu Families require consent from the family.**

**Tel: 8551 0500**

**DO NOT FAX**

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| REFERRER DETAILS | | | | | | |
| Consent for referral gained: | Does the referrer consent to this referral? | | | | | Y  N |
| Consent for Fleurieu Families to store data: | Fleurieu Families records client information on home data bases as a requirement. This will be discussed further with the client during first home visit.  Does the client give consent for their family’s information to be stored on Fleurieu Families client data bases? | | | | | Y  N |
| Date of Referral |  | | | | | |
| Name of Referrer |  | | | | | |
| Agency |  | | | | | |
| Postal Address |  | | | | | |
| Postcode |  | | Email |  | | |
| Landline |  | | Mobile |  | | |
| PRESENTING CLIENT DETAILS (Parent/caregiver) | | | | | | |
| Surname |  | | | | | |
| First Name |  | | | | | |
| Preferred Name |  | | Gender: Female  Male  Self-described  Client declined/chose not to answer | | | |
| Date of Birth (or EDB) |  | |  | | | |
| Role in Family (relationship status): |  | | | | | |
| Is any person Aboriginal or Torres Strait Islander? | Unknown  Aboriginal  Torres Strait Islander  Both | | Do any clients identify as LGBTIQ+ | Y  N  Unknown  Prefer not to say  Details: | | |
| Address |  | | | | | |
| Suburb |  | | Post Code |  | | |
| Landline |  | | Mobile |  | | |
| Does client have their own transport? Y  N  Unknown | | | | | | |
| CONSIDERATIONS – ALERTS, SAFETY, LEGAL ETC. Please note: Fleurieu Families staff do not provide legal advice | | | | | | |
| (Information in this section can include but not be limited to worker safety concerns, family law needs, orders etc.) | | | | | | |
| Other Additional Information | | | | | | |
| Does the client have an NDIS care plan? | | Y  N  Unknown | | | Details: | |
| Does the client have access to stable accommodation? | | Y  N  Unknown | | | Details: | |
| Does the family belong to a CALD community? | | Y  N  Unknown | | | Details: | |
| Does the client/any member of the family have any mental health conditions? | | Y  N  Unknown | | | Details: | |
| Is there current or past family violence for the client? | | Y  N  Unknown | | | Details: | |

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| **Other Additional Information** |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Parent/Carer/Family | | Age | Gender | Date of Birth or  EDB | Role in Family (relationship status) | Resides with Client (Y/N) | | Contact Details (If different from clients) |
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| Children(s) name | | Age | Gender | Date of Birth or EDD | Role in Family | Resides with Client (Y/N) | | Contact Details (If different from clients) |
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| Supporting Agency Name(s) | Contact Person | | | Role and Purpose (Open and Close) | | | Contact Number | |
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| PRESENTING ISSUES |
| **Current Situation/Incident (reason for referral):**  *(Outline* ***relevant*** *information for each family member)* |
| **Other Presenting Themes/Needs:**  *(Outline relevant information for each family member)* |
| **Child Protection History/Other Service History:**  *(Chronology of events for all significant others – outline* ***relevant*** *information for each family member)* |
| **Aims/ Goals of Service Intervention:**  *(Further assessment required/ identified service/ safety plan, motivation and readiness etc – outline* ***relevant*** *information for each family member)* |
| **Referrer comments/recommendations/assessment:**  **Home visit completed Y  N**  **Children sighted Y  N** |

**PLEASE FORWARD BY EMAIL TO: fleurieufamilies@victor.sa.gov.au**

**Or POST (marked CONFIDENTIAL) TO:**

**Fleurieu Families**

**C/- City of Victor Harbor**

**PO BOX 11, VICTOR HARBOR SA 5211**