



REFERRAL / INTAKE FORM

Date	
Worker contacted	

Client Consent (for other than self-referrals) <input type="checkbox"/> Yes <input type="checkbox"/> No (Referrer Must Obtain Consent)	
Referrer Name	Organisation
Phone	Feedback Required <input type="checkbox"/> Yes <input type="checkbox"/> No
Email	

Confidentiality policy explained to client (for self-referrals) <input type="checkbox"/> Yes <input type="checkbox"/> No
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Confidentiality policy to be explained to client: All information we collect is confidential - We do not provide any identifying information to a 3rd party unless we believe a client has either harmed or intends to harm themselves or someone else, or it is required by law. We may use de-identified information for data collection.

Name of Client	DOB
Address	
Suburb	P/Code
Phone	Mobile
Email	

Names of other Family members		Age	Gender
Partner	D.O.B		
Child	D.O.B		
Child	D.O.B		
Child	D.O.B		
Child	D.O.B		

Do we have permission to leave a message on these numbers?

Yes No

Referral Information	
<ul style="list-style-type: none"> How did you hear about this service? <input type="checkbox"/> Health <input type="checkbox"/> School <input type="checkbox"/> Childcare <input type="checkbox"/> Playgroup <input type="checkbox"/> Parent Group <input type="checkbox"/> Other Name of Organisation: 	

Is the client Aboriginal or Torres Strait Islander?	<input type="checkbox"/> No <input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander
What is the cultural background of Parents/Carers?	
What is the language spoken most often at home?	<input type="checkbox"/> English <input type="checkbox"/> Other, please specify:
Is an Interpreter required?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Reasons for referral (please tick)	
<input type="checkbox"/> Essentials (groceries, vouchers, bill help etc)	
Details:	
<input type="checkbox"/> Evolve (parenting groups and programs)	
Details:	
<input type="checkbox"/> Enrich (provide further details on back page)	
<input type="checkbox"/> Family Work <input type="checkbox"/> Counselling <input type="checkbox"/> Play Therapy <input type="checkbox"/> Art Therapy	

Child Protection Concerns:			
Are there any concerns for the safety of the children?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is the Referrer aware of reports being made regarding the safety and/or well-being of the children?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Contact Orders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Apprehended Violence Orders	<input type="checkbox"/> Yes <input type="checkbox"/> No
Supervised Access Orders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parenting Orders	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bail Conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other	
Details: (safety concerns / reports / orders)			

Following questions for Enrich referrals (Family Work, Counselling, Play or Art Therapy)

What would be most useful for your family? In what way could Gateway be helpful to your family?

Who else is helping you with this? (friends, families, services?)

What is working for your family, or going well at the moment? (What are your family's strengths?)

Other issues

Parenting / Family

Mental Health

AOD:

Financial / Housing:

Health / Disability:

Other Agencies involved:

Agency 1:		Worker Name	
Contact Details		Will the agency continue	<input type="checkbox"/> Yes <input type="checkbox"/> No
Agency 2:		Worker Name	
Contact Details		Will the agency continue	<input type="checkbox"/> Yes <input type="checkbox"/> No

For Family Work referrals:

Is there any reason why it might not be safe to visit you at home? Yes No Unsure

- NB
1. Animals in the home:
 2. Other residents:
 3. Other:

**Once form is completed, please save and email to:
referrals@gatewayfamilyservices.org.au**