**CYFS Family Case Management Referral Form**

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| **Primary Referrer’s Details** |
| Referrer’s Name:  | Organisation: |
| Email address:  | Phone Number:  |
| Role/relationship to person being referred: | Referral date: |

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| **Consent** |
| Are the service users aware of the referral? | **Y/N** |
| Are the service users interested in receiving case management?  | **Y/N** |
| Has the service user provided verbal or written consent for this information to be shared?  | **Y/N**  |
| **Please note: Consent must be sought from primary client before referring to our program.**  |  |

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| **Primary Client Details** |
|  Name:  | D.O.B: | Gender:  |
| Phone: Is it safe to leave a message: **Y/N** | Email address: |
| Preferred contact method (Please circle): **Text Email Phone Call**Best days/times to contact: |
| Address: |

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| **Significant Others and Other Household Members** |
| Name | Gender & DOB | Relationship | School/ Childcare Attended |
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| **Families, Culture, Communication and Additional Needs** |
| Aboriginal/ Torres Strait Islander**: Y/N** Please specify:  |
| Other, please specify: |
| Country of Origin: | Primary language: Interpreter required: **Y/N** Language: |
| Additional Needs or Disability: **Y/N**Please specify:  | Medical Conditions**: Y/N**Please specify: |
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| **Reason for referral/ Presenting Issues/ Background Info** |
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|  Additional  | Information |
| Housing Status | **Public/ Private rental/ Owner with Mortgage** |
| Income type | **Centrelink/ Part Time employment/ Full time employment**  |
| Legal Matters/ Court Orders | **Y/N Please specify:** |
| Current CYPS involvement  | **Y/N**  |
| Safety/ Risk factors: | **Y/N Please Specify:**  |

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| **Goals Identified by Primary Client** |
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|  | **Other Services Involved with the family** |
| Organisation  | Service Being Provided | Family member being supported | Contact Name  | Phone number/Email |
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For any further information, please contact the CYFS Family Case Management Team on

**02 6282 2644**. Once completed please return to **fcm@wcs.org.au**.