

DATE OF INITIAL INTAKE

SECTION 1 REFERRAL AND CONSENT

Referral / Agency Details (IF APPLICABLE)

Referring Agency

Contact Person

Phone

Email

 Registration Type Phone Email Walk-in In-house

 How did you hear about us? Word-of-mouth Solicitor School Friend/Family Member Service Provider Other

Reason for Referral

All information on this form will be treated in accordance with the Marymead Privacy Policy.
This information is stored on a database and used for statistical purposes for our funding body. No-one outside Marymead has access to identified information stored on the database without the individuals' consent. With the individual's consent, information can be shared with external agencies.

Does the individual agree to provide information to Marymead? Yes No Unsure

Does the individual agree for Marymead and the referring agency to exchange information? Yes No Unsure

Does the individual agree for Marymead to provide information to other agencies? Yes No Unsure

Signature

Parent/guardian to sign if client is under 18

Date

SECTION 2 SERVICES

Support and areas of need

What service(s) are you seeking? (PLEASE CHOOSE SERVICE/S AND ASSOCIATED PROGRAM WHERE APPLICABLE)

Emotional Well-Being and Relationships	<input type="radio"/> Early Life Matters (COS) <input type="radio"/> New Horizons	<input type="radio"/> Parenting Groups <input type="radio"/> Counselling
Post Separation	<input type="radio"/> ARCK <input type="radio"/> KAYAKS	<input type="radio"/> Parenting after Separation
Contact Program	<input type="radio"/> Supervised Visits	<input type="radio"/> Changeover
Disability Programs		
Autism Support		
NSW Permanency Placement Program (Previously known as Foster Care)	<input type="radio"/> Permanency Support Program	<input type="radio"/> Permanency Support Training

Additional Comments

SECTION 3 PERSONAL AND FAMILY DETAILS

Name and details of person being referred to Service

Name

Address

Date of Birth DD/MM/YYYY

 Gender Male Female Other

Contact Number

Email Address

Aboriginal &/or Torres Strait Islander Yes No

Country of Birth

CRN Number

Main language spoken at home

 Marital Status Single Married Divorced Separated De-facto Other

Interpreter needed Yes No

SECTION 3 PERSONAL AND FAMILY DETAILS CONTINUED

Details of Family Members - Children/Parents/Siblings/Significant Others

Name	Gender	Date of Birth DD/MM/YYYY	Relationship	Aboriginal &/or Torres Strait Islander		Country of Birth	Year of arrival in Australia	Disability
				Yes	No			
				Yes	No			
				Yes	No			
				Yes	No			
				Yes	No			
				Yes	No			

Contact Details for Parents/Carers

EMERGENCY CONTACT	Name	Relationship	Phone
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OTHER CONTACTS	Contact Person 1	Contact Person 2	Contact Person 3
Name			
Address			
Phone			
Email			
Permission to Contact	Yes No Unsure	Yes No Unsure	Yes No Unsure
Aware of Referral	Yes No Unsure	Yes No Unsure	Yes No Unsure

Who is the Primary Caregiver? Parent Grandparent Sibling Carer Other relative Other non-relative

Is the child or children in Out of Home Care? Yes No Unsure

If Yes, please list names of child/ren

SECTION 4 RELATIONSHIPS AND CURRENT LEGAL ISSUES

PERSONAL DETAILS – Primary client

The following questions help to assist us in understanding care relationships, family and support networks such as friends and significant others.

Do you have a formal/informal support network? Yes No

If Yes, please give a brief description

Have you ever felt unsafe in your home? Yes No Is the abuse ongoing? Yes No

Which form of abuse have you experienced?

Physical abuse Emotional abuse Verbal abuse Financial abuse Social abuse Sexual abuse Stalking

If Yes, briefly describe current or previous abuse

Are there any current court orders or other legal issues?

If Yes, which type? Custody AVO - Apprehended Violence Order DVO - Domestic Violence Order FVO - Family Violence Intervention Orders

Expiry Date Order Type Interim Consent Final

Parties named on orders

Copy of court orders attached? Yes No If Yes, please give a brief description

Copy of court orders requested? Yes No

NOTE: PLEASE PROVIDE A COPY OF COURT ORDERS IN RELATION TO CUSTODY AND COMPULSORY EDUCATION/GROUPS.

Is there any ongoing or previous involvement by Statutory Child Protection Services?

If Yes, please give a brief description

SECTION 4 RELATIONSHIPS AND CURRENT LEGAL ISSUES CONTINUED

Legal Guardianship and Access Arrangements

Sole Parental Responsibility	Parent Name	
Shared Parental Responsibility	Parent Name	Parent Name

Choose one of the following options that describe your custody arrangements Formal
 Informal

Choose one of the following options that describe your custody arrangements
 Full-time with one parent 50/50 60/40 70/30 80/20 90/10
 Other

If Other, briefly describe

SUPERVISED CONTACT

Choose preferred options Days Time Location

Legal Representation

State details

SECTION 5 EMOTIONAL WELL-BEING, ALCOHOL AND OTHER DRUGS

Alcohol and Other Drugs

Please describe any emotional or behavioral struggles that you and your child are currently living with?

Parent Name	Yes	No	If Yes, briefly describe
Child Name	Yes	No	If Yes, briefly describe
Do you have a formal diagnosis? (ONLY IF APPLICABLE)	Yes	No	Unsure

Does anyone in the household have a history with alcohol or drug use?

If Yes, tick all substances that apply

Alcohol Cannabis Cocaine Heroin ICE Methamphetamines
 Prescription (E.g. Morphine, Methadone, Codeine, Valium) Hallucinogens (E.g. LSD, Ecstasy, Ketamine)
 Performance and Image Enhancing Drugs (PIEDs) (e.g. Steroids)

Number of times used in the past 7 days?

Number of times used in the past four weeks?

How long have you been using?

Have you undergone rehabilitation?

Current Support Services in place. List details

SECTION 6 HEALTH AND DISABILITY

Health and Disability Details

Known Allergies and for whom Yes No Unsure If Yes, please specify

Is anyone in the household living with a disability or illness? Yes No Unsure If Yes, please specify

DISABILITY

Choose one or more disabilities from the following list

ASD - Autism Spectrum Disorder ADHD - Attention-Deficit/Hyperactivity Disorder OCD - Obsessive Compulsive Disorder
 Anxiety Depression Eating Disorder (E.g. Anorexia) Mood Disorder (E.g. Bipolar) Trauma and Stress Related Disorder (E.g. PTSD)
 Personality Disorder (E.g. Borderline Personality Disorder) Psychotic Disorder (E.g. Schizophrenia) Other

If Other, please state

Do you have a formal diagnosis? Yes No If Yes, specify date

SECTION 6 HEALTH AND DISABILITY CONTINUED

Health and Disability Details

Choose severity of disability by completing this sentence. **Individual manages needs...**

Are there any mental health concerns? Yes No If Yes, briefly describe

Are there any physical health concerns? I

Brief description of the most recent episode, if applicable

Do you have concerns they pose a risk to self harm and/or others? Yes No If Yes, briefly describe

NDIS - National Disability Insurance Scheme

Does anyone in the household have or is seeking NDIS funding?

If you have an NDIS package, will Marymead services be received under the package? Yes No Unsure

A copy of your NDIS Package is attached to this form Yes No

A NDIS package has been requested Yes No

Case Manager Name Phone

Email

Address

SECTION 7 CONCLUDING REMARKS

Are there any other concerns or risk factors that you would like to make us aware of?

List Details