

**Referral to the following QEC Parenting Assessment and Skill Development Service**

Please tick program choice:

[ ]  **Residential 10 day onsite**

[ ]  **Home Based**

# Please note that all sections must be completed before forwarding referral to QEC. Refer to QEC PASDS Referrals Factsheet on QEC website for information of how to complete and send this referral

# Referring Child Protection Team

|  |  |
| --- | --- |
| Team Managers Name:  |  |
| Direct Telephone Number: |  | Mobile Number: |  |
| Fax Number: |  | Email Address: |  |
| DHHS Allocated Worker |  |
| Direct Telephone Number: |  | Mobile Number: |  |
| Fax Number: |  | Email Address: |  |
| Practice Leader |  |
| Direct Telephone Number: |  | Mobile Number: |  |
|  |  | Email Address: |  |
| DHHS Office, Address, Phone: |  |
| Date of referral preparation: |  |

**Names of parent/carer/s and child/children being referred to the PASDS program.**

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**Relationship of the parent/carer/s (named above) to the child/children being referred to the PASDS program.**

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# Reason for Referral

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| [ ]  Child protection referral – protective intervention purposes[ ]  Child protection referral – for investigation[ ]  Child protection referral – for reunification purposes[ ]  Child protection referral – for consideration of out of home placement[ ]  Court referral – for reunification purposes[ ]  Court referral – for consideration of out of home placement[ ]  Unborn child response (ante natal) |

Has this referral and program been discussed with the family? Yes [ ]  No [ ]

If yes, did family consent to participate in the program? Yes [ ]  No [ ]

# Parent/Carer Details

|  |  |  |
| --- | --- | --- |
|  | **Caregiver 1 to be Assessed** | **Caregiver 2 to be Assessed** |
| **Surname** |  |  |
| **Given Names** |  |  |
| **Gender** | [ ]  Male[ ]  Female[ ]  Other - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  Male[ ]  Female[ ]  Other - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Marital Status** |  |  |
| **Date of Birth** |  |  |
| **Country of Birth** |  |  |
| **Year of Arrival**(if not born in Australia) |  |  |
| **Culture and Religion** |  |  |
| **Address** |  |  |
| **Suburb/Town and Postcode**  |  |  |
| **Phone Number /Mobile** |  |  |
| **Email Address** |  |  |
| **Education Level** | [ ]  Year 9 – 10[ ]  VCE or equivalent[ ]  Undergraduate Degree[ ]  Other:  | [ ]  Year 9 – 10[ ]  VCE or equivalent[ ]  Undergraduate Degree[ ]  Other:  |
| **Family Income** | [ ]  Newstart/Jobsearch allowance[ ]  Sole parent pension[ ]  Disability support pension[ ]  Family Assistance[ ]  Family Tax Benefit[ ]  Employed[ ]  Other pension / benefit[ ]  Young homeless allowance | [ ]  Newstart/Jobsearch allowance[ ]  Sole parent pension[ ]  Disability support pension[ ]  Family Assistance[ ]  Family Tax Benefit[ ]  Employed[ ]  Other pension / benefit[ ]  Young homeless allowance |
| **Language Spoken:** |  |
| **Is an interpreter required** | [ ] Yes[ ] No |
| **If yes, booked by:**  |  |

Are any of the family of Aboriginal or Torres Strait Islander descent? [ ]  Yes [ ]  No

If yes, please tick applicable box below:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Aboriginality – if applicable** | **Primary Carer** | **Secondary Carer** | **Child 1** | **Child 2** | **Child 3** |
| Aboriginal origin |[ ] [ ] [ ] [ ] [ ]
| Aboriginal and Torres Strait Islander origin |[ ] [ ] [ ] [ ] [ ]
| Torres Strait Islander origin |[ ] [ ] [ ] [ ] [ ]
| Neither Aboriginal/Torres Strait Islander origin |[ ] [ ] [ ] [ ] [ ]

|  |  |
| --- | --- |
| **Cultural needs** |  |
| **Spiritual needs** |  |

|  |  |  |
| --- | --- | --- |
|  | **Primary Carer** | **Secondary Carer** |
| **Card Details****Medicare Card Number** |  |  |
| **Expiry Date** |  **/ Suffix** |  **/ Suffix** |
| **Health Care Card Number** |  |  |
| **Expiry Date** |  **/**  |  **/**  |

**Child/ren details**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Child 1** | **Child 2** | **Child 3** |
| **CRIS. Number****(Eldest Child Admitted)** |  |  |  |
| **Surname** |  |  |  |
| **Given Names**  |  |  |  |
| **Gender**  | [ ]  Male[ ]  Female[ ]  Other - \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  Male[ ]  Female[ ]  Other - \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  Male[ ]  Female[ ]  Other - \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Date of Birth** |  |  |  |
| **Country of Birth** |  |  |  |
| **Year of Arrival** (if not born in Australia) |  |  |  |
| **Child’s Address** (if not the same as either carer |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Child 1** | **Child 2** | **Child 3** |
| **Child Residential Status** (if with carer please also complete Section 5 & provide with referral) |  |  |  |
| Does the child have a My Health, Learning & Development book? | [ ] Yes[ ] No | [ ] Yes[ ] No | [ ] Yes[ ] No |
| **Access Arrangements**Has the child had regular contact with parents? |  |  |  |
| **Feeding**Outline current routine, meals, likes & dislikes |  |  |  |
| **Settling**Outline current sleep routines and settling strategies |  |  |  |
| **Behaviour**Outline any behavior concerns |  |  |  |
| **Medical**List any medications |  |  |  |
| **Immunisation Status** |  |  |  |

**Health and Development of child/ren: (include date of last Maternal and Child Health nurse visit)**

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| **Emergency Contact** |
| Name: |  |
| Relationship to Primary Carer: |  |
| Address: |  |
| Phone: |  |

Family Structure (if different from above, include extended family, carers, significant others):

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| --- | --- | --- | --- |
| **Name** | **Relationship** | **DOB** | **Address & Contact Number** |
|  |  |  |  |
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DFFH involvement and relevant family background:

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|  |

Protective concerns: (most recent report, current protective concerns)

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|  |

Current legal factors (access/contact arrangements/court orders/children’s court/conditions in place)

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Identified parenting strengths and areas for development, including family goals:

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**History of Family Violence / Outcome of Family Violence Risk Assessment:**

Is there a history of aggression/violence/escalation? [ ] Yes[ ] No

If yes, is report/information attached? [ ] Yes[ ] No

Further information:

|  |
| --- |
|  |
|  |

Has family violence service been consulted? [ ] Yes[ ] No

If yes, is report/information attached? [ ] Yes[ ] No

Further information:

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When was the last family violence screening completed? Date:……………………

If yes, is report/information attached? [ ] Yes[ ] No

Outcome of this screening:

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Is there a safety plan in place? [ ] Yes[ ] No

If yes, is report/information attached? [ ] Yes[ ] No

Further information:

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Is there a family history of criminal offenses? Criminal court/bail conditions Detail below:

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| --- |
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**History of Substance Abuse**

Is there any history of any of the Caregivers using addictive substances? [ ]  Yes [ ]  No

|  |  |
| --- | --- |
| What substances?  |  |
| If yes, caregivers name/s: |  |

Is he/she on a recognised rehabilitation program? [ ]  Yes [ ]  No

If yes, please advise the name of the Methadone (or other) prescribing GP and contact details (below) so that an application can be made for the transfer of this medication for the period of the admission.

|  |  |  |
| --- | --- | --- |
| **Name** | **Telephone No.** | **Fax No.** |
|  |  |  |

Do any of the Caregivers have a history of taking alcohol in excessive amounts? [ ]  Yes [ ]  No

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| --- | --- |
| If yes, caregivers name/s: |  |

Are there any referrals in place to be linked to an AOD worker prior to PASDS commencing? [ ]  Yes [ ]  No

Are they required to complete any court ordered screens (or voluntary). Have they been complying? [ ]  Yes [ ]  No

Is cannabis use is present: [ ]  Yes [ ]  No

If yes, QEC need 3 copies of consecutive screens showing reduction/or stable levels.

[ ]  Confirmed screens are attached: \_\_\_\_\_ (Initial)

Additional information:

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**History of Mental Health**

Has caregiver had a recent mental health assessment? [ ]  Yes [ ]  No

[ ]  If yes, confirmed report attached: \_\_\_\_\_ (Initial)

Can a copy of the report be provided to QEC? [ ]  Yes [ ]  No

Additional information:

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**Cognitive Functioning**

Has the caregiver previously had a cognitive assessment completed? [ ]  **Yes** [ ]  **No**

If yes, can a copy of the report be provided to QEC? [ ]  **Yes** [ ]  **No**

[ ]  If yes, confirmed report attached: \_\_\_\_\_ (Initial)

If no, does the caregiver need a cognitive assessment? [ ]  **Yes** [ ]  **No**

**NOTE: if response is YES to above question, DFFH will need to arrange this prior to admission to QEC**

Additional information:

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**Medication**

Is the caregiver on any medication? [ ]  Yes [ ]  No

Are there any side effects? [ ]  Yes [ ]  No

If yes, please specify:

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**History of Psychiatric Illness**

Do any of the caregivers have a history of psychiatric illness? [ ]  Yes [ ]  No

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| If yes, caregivers name/s: |  |

If there is a history of any of substance abuse or psychiatric illness, please include details, including psychiatrist’s/ psychologist’s name and phone number plus a written report from treating specialist.

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| --- | --- | --- | --- | --- |
| **Name** | **Role/Service provided** | **Address** | **Telephone** | **Report provided** |
|  |  |  |  | [ ]  Yes [ ]  No |
|  |  |  |  | [ ]  Yes [ ]  No |
|  |  |  |  | [ ]  Yes [ ]  No |

Additional information:

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| --- |
|  |

Other services currently involved with family

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| --- | --- | --- | --- | --- |
| **Name** | **Role/Service provided** | **Address** | **Telephone** | **Report provided** |
|  |  |  |  | [ ]  Yes [ ]  No |
|  |  |  |  | [ ]  Yes [ ]  No |
|  |  |  |  |  [ ] Yes [ ]  No |

Further Information

(e.g. worker safety alerts, medical issues, developmental issues, details of restricted visitors)

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|  |

Has any family member previously received a QEC service?(Residential, Daystay or Home Based)[ ]  Yes [ ]  No

If yes, please specify:

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| --- | --- | --- |
| **Client** | **Date** | **Type of Service** |
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**Home based PASDS (the next 3 questions to be completed for home based referrals only)**

What is the current housing situation? Where will program occur?

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Please specify who resides at the premise (e.g. grandparents/alternate caregivers)

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Family’s availability for visits (e.g. employment situation) Note program hours Monday- Friday 9-5pm

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# Infant Caregivers Referral Information Sheet

QEC

53 Thomas Street

Noble Park VIC 3174

Phone: (03) 9549 2777

FAX: (03) 9549 2779

Dear Caregiver,

The purpose of this referral information form is to gather additional information regarding, habits and routines established so as to make the transition to the *QEC* residential program as smooth and consistent as possible.

If you have the child/ren’s **My Health, Learning & Development** book, please bring this on admission. Thank you for your co-operation.

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| Child’s name and date of birth |
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| How long has the child resided with you? |
|  |
| Feeding: please outline current meals, routines, likes and dislikes |
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| Settling: please outline sleep routines and settling strategies |
|  |
| Behaviour: please outline any behaviour of concern and current management strategies. |
|  |
| Medical: List any recent illness, medications, immunisation status |
|  |
| Access Arrangements: Has the child had regular contact with his/her parents? |
|  |
| Further Comments: |
|  |