

**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

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| --- | --- | --- |
|  | **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** | YesNo | |
| **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 |  |  |  |  |  |

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| --- | --- |
| **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 |  |  |  |

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| --- | --- | --- | --- |
|  | **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? | YesNo | YesNo | YesNo |
| **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? YesNo

If yes, is report/information attached? YesNo

Further information:

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Has family violence service been consulted? YesNo

If yes, is report/information attached? YesNo

Further information:

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

If yes, is report/information attached? YesNo

Outcome of this screening:

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Is there a safety plan in place? YesNo

If yes, is report/information attached? YesNo

Further information:

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

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**History of Substance Abuse**

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

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| --- | --- |
| 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.

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| --- | --- | --- |
| **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. |
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| Medical: List any recent illness, medications, immunisation status |
|  |
| Access Arrangements: Has the child had regular contact with his/her parents? |
|  |
| Further Comments: |
|  |