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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Please tick program choice:  **QEC Parenting Assessment and Skill Development Service (PASDS)**  Referral Form  ​​☐​ Residential 10-day telehealth  ​​☐​ Residential 10-day onsite  ​​☐​ Residential 10-day combination of telehealth and 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.  |  | | --- | |  | |  |  Relationship of the parent/carer/s (named above) to the child/children being referred to the PASDS program.  |  | | --- | |  | |  |    Reason for Referral ​​☐​ 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 – 11  ​​☐​VCE or equivalent  ​​☐​Undergraduate Degree  ​​☐​Other: | ​​☐​Year 9 – 11  ​​☐​VCE or equivalent  ​​☐​Undergraduate Degree  ​​☐​Other: |
|  |  |  |
|  | Caregiver 1 to be Assessed | Caregiver 2 to be Assessed |
| Family Income | ☐​ Centrelink Payment type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ☐ ​Family Assistance  ☐​ Family Tax Benefit  ☐ ​Employed  ☐​ Other pension / benefit | ☐​ Centrelink Payment type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ☐ ​Family Assistance  ☐​ Family Tax Benefit  ☐ ​Employed  ☐​ Other pension / benefit |
| Language Spoken: |  | |
| Is an interpreter required | **​​☐​** Yes**​☐​** No | |
| If yes, booked by: |  | |

## 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 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 |

|  |  |  |  |
| --- | --- | --- | --- |
|  | Child 1 | Child 2 | Child 3 |
| 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* |  |  |  |
| Behavior*Outline any behavior concerns* |  |  |  |
| Medical*List any medications* |  |  |  |
| Immunization Status |  |  |  |

|  |  |
| --- | --- |
| Health and Development of child/ren: (include date of last Maternal and Child Health nurse visit)  |  | | --- | |  |  First Nations Status |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Primary Carer | Secondary Carer | Child 1 | Child 2 | Child 3 |
| Aboriginal | ​​☐​ | ​​☐​ | ​​☐​ | ​​☐​ | ​​☐​ |
| Aboriginal and Torres Strait Islander | ​​☐​ | ​​☐​ | ​​☐​ | ​​☐​ | ​​☐​ |
| Torres Strait Islander | ​​☐​ | ​​☐​ | ​​☐​ | ​​☐​ | ​​☐​ |
| Neither Aboriginal/Torres Strait Islander | ​​☐​ | ​​☐​ | ​​☐​ | ​​☐​ | ​​☐​ |

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

## Emergency Contact

|  |  |
| --- | --- |
| Name: |  |
| Relationship to Primary Carer: |  |
| Address: |  |
| Phone: |  |

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

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Relationship | DOB | Address & Contact Number |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

|  |
| --- |
| Please describe: |

## DFFH involvement and relevant family background:

|  |
| --- |
|  |

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

|  |
| --- |
|  |

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

|  |
| --- |
|  |

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

|  |
| --- |
|  |

## 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 a family violence service been consulted? **​☐​** Yes**​☐​** No

### When was the last family violence screening completed? Date: \_\_\_\_\_\_\_\_\_

### Is there a safety plan in place? **​☐​** Yes**​☐​** No

### Is there a current Family Violence Intervention Order or Safety Notice place? **☐​** Yes**​☐​** No

### Who was the perpetrator named in the IVO or SN? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### If yes to any of the above, is report/information attached? **☐​** Yes**​☐​** No

### Further information:

|  |
| --- |
|  |

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

|  |
| --- |
|  |

## Substance Use

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

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  |  |  |  | | --- | --- | --- | --- | | Caregiver | Substance(includes excessive alcohol use or drugs of addition) | Current Usage Yes/No | Currently engaged in a recognized rehabilitation program Yes/No | |  |  |  |  | |  |  |  |  | |

### If a Caregiver is being prescribed Methadone (or other) please provide 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.

|  |  |  |  |
| --- | --- | --- | --- |
| Caregiver | Medical Practitioner Name | Telephone No. | Fax No. |
|  |  |  |  |
|  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Caregiver | Any referrals in place to be linked to an AOD worker prior to PASDS commencing?Yes/No/Details | Any court ordered or voluntary drug screens?Yes/No | Have they been complying with drug screens?Yes/No/ Not consistently | Is cannabis use present?Yes/No |
|  |  |  |  |  |
|  |  |  |  |  |

### QEC need 3 copies of consecutive screens showing reduction/or stable levels

### Confirmed screens are attached? ​☐​ Yes      ​☐​ No \_\_\_\_\_\_\_\_\_(Initial)

Additional information:

|  |
| --- |
|  |

## Mental Health

### Does the parent/caregiver have a history of mental health illnesses? (Please specify below if ticked yes) ​☐​ Yes    ​☐​ No

|  |  |  |  |
| --- | --- | --- | --- |
| Caregiver | Mental Health Diagnosis | Dates diagnosed | Status of Mental Health illness |
|  |  |  |  |
|  |  |  |  |

### Has the caregiver had a recent mental health assessment? ​☐​ Yes    ​☐​ No

### Has a copy of the report been provided to QEC? ​☐​ Yes    ​☐​ No

### Additional information:

|  |
| --- |
|  |

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

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Caregiver | Practitioner Name | Role/Service provided | Address | Telephone | Report provided |
|  |  |  |  |  | ​​☐​ Yes ​☐​ No |
|  |  |  |  |  | ​​☐​ Yes ​☐​ No |
|  |  |  |  |  | ​​☐​ Yes ​☐​ No |
|  |  |  |  |  | ​​☐​ Yes ​☐​ No |

### Additional information:

|  |
| --- |
|  |

## Medication

### Is the caregiver on any medication?

|  |  |  |  |
| --- | --- | --- | --- |
| Caregiver | Medication | Dosage | Side Effects |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

## Cognitive Functioning / Acquired Brain Injury assessments

|  |  |  |
| --- | --- | --- |
| Caregiver | Has the Caregiver had a cognitive or ABI assessment previously?Yes/No | Does the Caregiver need a cognitive or ABI assessment?Yes/No |
|  |  |  |
|  |  |  |

### NOTE: if the Caregiver needs a cognitive or ABI assessment, DFFH will need to arrange this prior to admission to QEC

## Other services currently involved with family

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name | Role/Service provided | Address | Telephone | Report provided |
|  |  |  |  | ​​☐​ Yes ​☐​ No |
|  |  |  |  | ​​☐​ Yes ​☐​ No |
|  |  |  |  | ​☐​Yes ​☐​ No |

## Further Information (e.g. worker safety alerts, details of restricted visitors, other)

|  |
| --- |
|  |

## Has any family member previously received a QEC service?(*Residential, Daystay or Home Based*)

### ​☐​ Yes     ​☐​ No

## If yes, please specify:

|  |  |  |
| --- | --- | --- |
| **Client** | **Date** | **Type of Service** |
|  |  |  |
|  |  |  |

## 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?

|  |
| --- |
|  |

### Who resides at the premise? (e.g. grandparents/alternate caregivers/co-tenants)?

|  |
| --- |
|  |

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

|  |
| --- |
|  |

**QEC Parenting Assessment and Skill Development Service (PASDS)**

Parent/Caregiver Information

### QEC

### 53 Thomas Street

### Noble Park VIC 3174

### Phone: (03) 9549 2777

### FAX: (03) 9549 2779

### 

### Dear Family,

### This form tells us about you and your child’s habits and routines. This information helps us support you come into the QEC residential program as smoothly and easily as possible.

### 

### If you have your child/ren’s **My Health, Learning & Development “Green book”,** please bring this with you to the QEC.

|  |
| --- |
| Child/ren’s name and date of birth |
|  |
| How long have the child/ren lived with you? |
|  |
| Please tell us about your child/ren’s meals, routines, likes and dislikes. |
|  |
| Please tell us about your child/ren’s sleep routines and how you help them go to sleep. |
|  |

|  |
| --- |
| Please tell us about any of your child/ren’s behaviour that worries you and how you manage this. |
| Please tell us about any of your child/ren’s recent illness, medications, immunisation status |
|  |
| Has the child/ren had regular contact with his/her parents? |
|  |
| Further Comments: |
|  |