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| --- | --- |
| **Temcare: Referral Form** Date of Referral:  |  |
| **Name of referrer:**  |  |
| **Referring agency [if applicable]:**  |  |
| **Contact details of referrer:**  | **Phone:** **Email:****Postal address:** |
| **Name of the family being referred:**  |  |
| **Name of parent/carer/responsible adult:** |  |
| **Contact details for family:**  | **Phone:****Email:****Address:** |
| **Details of the person/people requiring a Temcare program [parent mentoring, Women of Hope, family support, Respite, Mates]:** |
| **Name:** | **D.O.B:**  | **Adult/child:** | **Program:** |
| **Name:** | **D.O.B:**  | **Adult/child:** | **Program:** |
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| **Name:** | **D.O.B:**  | **Adult/child:** | **Program:** |
| **Other people [adults and children] living within the family]. Please include their D.O.B:**  | **1.** |
| **2.** |
| **3.** |
| **4.** |
| **5.** |
| **Relevant information relating to the cultural identification [particularly Aboriginal or Torres Strait Islander background] of the person being referred:**  |  |
| **Reasons for referral [including how you believe the Temcare program will assist]:** |  |
| **Significant issues within the family [e.g. family violence, mental health, child protection, housing, substance and/or alcohol abuse, parental special needs, culture/language]** |  |
| **Child behavioural Issues:**  |  |
| **Child special needs [e.g. disabilities, medication, mental health, toileting, development]:**  |  |
| **Current services involved:** 1.
 |
| **Previous services involved:** |
| **Additional information or background:**  |