|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 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 [Respite Care, Mates Mentoring, Youth Worker Support, Family Services, Play Therapy, Women of Hope support group]:** | | | | | |
| **Name:** | | **D.O.B:** | **Adult/child:** | **Program:** | |
| **Name:** | | **D.O.B:** | **Adult/child:** | **Program:** | |
| **Name:** | | **D.O.B:** | **Adult/child:** | **Program:** | |
| **Name:** | | **D.O.B:** | **Adult/child:** | **Program:** | |
| **Name:** | | **D.O.B:** | **Adult/child:** | **Program:** | |
| **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:** | | | | | |
| **Previous services involved:** | | | | | |
| **Additional information or background:** | | | | | |