

DATE OF REFERRAL:

CLIENT SURNAME:

<u>ELIGIBILITY CHECK LIST</u>	
Family with children 12 years and under <i>(including expectant mothers)</i>	YES/NO
Residing in West Lake Macquarie <i>(Booragul to Wyee for case management)</i>	YES/NO
<i>Please note we cannot accept referrals where there is an open child protection case</i>	



FAMILY INFORMATION

Client Name:..... Age / D.O.B:..... Gender:

Address:.....

Postcode: Phone: Mobile:.....

Is the client Aboriginal or Torres Strait Islander? YES/ NO

Does the client speak a language other than English? YES / NO

Will the client require an interpreter? YES/NO

Does the client have any diagnosed disability?

Partner's name:

CHILDREN:

Name & Gender	Date Of Birth	Any diagnosed disability? YES/NO required	Aboriginal or Torres Strait Islander? YES/NO required	Speak language other than English? YES/NO required	School or childcare centre

Current issues/needs/relevant information:

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REFERRAL INFORMATION

Referred by: (name of worker)

Of: (name of Agency)

Phone contact: (agency contact number)

Email address:

Will the agency continue to work with the family? YES/NO

If yes, in what capacity?

OTHER AGENCIES INVOLVED WITH FAMILY:

AGENCY	WORKER (Name & contact no.)

SAFETY/CHILD PROTECTION ISSUES

Are there any home visiting/child protection safety issues? YES/NO

Comments:

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FOR CALM OFFICE STAFF ONLY

Date referral received:

Referral Taken By:

Service Required:

Action Taken:

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CALM C&F INTAKE ASSESSMENT

DATE:	ACCEPTED FOR ASSESSMENT: YES/NO
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WORKER ALLOCATED:	INITIAL ASSESSMENT DATE:
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ACCEPTED/DECLINED CASE MANAGEMENT:

Send Referral to: Child & Family Team CALM by FAX- **02 4959 6810**
OR email Denise@calm.org.au OR phone **4950 3855**