Hindmarsh Supported playgroup referral

Date:_____

Referral To	Referral From
Name: Ellen Wheaton	**Name:**
Position: Supported Playgroup Facilitator	**Position:**
Service Provider: Hindmarsh Shire Council	**Service Provider:**
Email: EWheaton@hindmarsh.vic.gov.au	**Email:**
Phone Number: 0417 020 329	**Phone Number:**
	Type of service: ☐Health practitioner ☐GP ☐MCH ☐Community Services Agency ☐ChildFirst/Child protection ☐ECEC service ☐Other:
Carer Details	
Surname:	**Given Names:**
Given Names:	
Gender:☐ M ☐ F ☐Prefer not to state ☐Other	
DOB:	
Phone Number:	**Preferred Method: ☐SMS ☐Phone call**
Home Address:	
Suburb and postcode:	
Email:	
Language: **Interpreter required ☐Yes ☐ No**	
Referred client, or anyone in household has a healthcare card or equivalent visa category?	**☐Yes ☐No ☐Not Stated**
Access to Supported playgroup discussed with Family?	**☐Yes ☐No ☐Not Stated**
Other Services currently accessed by family:_____ _____ _____ _____	
Notes:_____ _____ _____ _____	

Referral Information			
Issues that carer felt a supported playgroup may assist with: _____ _____ _____			
Reason for referral as identified by service provider: _____ _____ _____			
Details of child/ren			
	Child One	**Child Two**	**Child Three**
Family name:			
Given Names:			
DOB:			
Gender:			
Of Aboriginal or TSI origin?	☐Yes ☐ No	☐Yes ☐ No	☐Yes ☐ No
In a kinship care arrangement:	☐Yes ☐ No	☐Yes ☐ No	☐Yes ☐ No
Has the child been diagnosed with a developmental disability? **If yes provide details:**	☐Yes ☐ No	☐Yes ☐ No	☐Yes ☐ No
If MCH, are children up to date with ages and stages visits?	☐Yes ☐No ☐Not Stated	☐Yes ☐No ☐Not Stated	☐Yes ☐No ☐Not Stated
Emergency Contact			
Name:			
Phone number:	**Relationship:**		