

**PUP Facilitator:** Michelle

**Phone:** 9239 1916

**E-mail:** Attach@unitingwa.org.au

**REFERRAL DETAILS:**

Referral Date:

Name of Referrer:

Organisation:

Contact Address:

Phone: Fax:

Email:

**CLIENT DETAILS:**

Client Name: DOB:

Address:

Phone: Mobile:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Partnered: | Single | Aboriginal or TSI: | YES | NO |
|  |  | CaLD Background: | YES | NO |

Country of Birth: Preferred language: Housing Details:

Is client renting privately: Yes No Is client in public housing: Yes No

Is client home mortgaged or owned: Yes No Is client at risk of homelessness: Yes No Significant others’ contact details:

Name:

Mobile:

|  |  |  |
| --- | --- | --- |
| Does the client have a child 0-12 years old in their care? | YES | NO |
| Is the client currently pregnant? | YES | NO |

If so, what is the estimated date of delivery?

**FAMILY DETAILS:**

Please complete table below and include **ALL** people who live in the family home (including client):

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Surname** | **First Name** | **DOB** | **M/F** | **Relation** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**REASON FOR REFERRAL:**

**PARENTING**

**GOALS:**

**FAMILY’S STRENGTHS:**

**Alcohol and/or other drugs (history, use, treatments etc)**

**Mental Health History:**

Any prior hospitalisation:

Diagnoses/Current Medication:

Current Mental Health Issues:

Past Mental Health Issues:

Self Harm/Suicide Attempts:

**Are there any known risks to worker safety? (Please include history of violence, convictions, threats, pets etc)**

**Other agencies involved with the family (please provide agency name and contact details)**

**Any other important information (CPFS involvement, health concerns, disabilities etc)**

To be completed by the family being referred:

I am aware of the contents of this referral. I give permission for the referral to be made and for the referrer and Uniting WA to exchange information regarding this referral.

Name Signed Date

Name Signed Date

***Office Use Only: Referral taken by: Date:***