Parents Under Pressure (PUP) Program Referral Form

**PUP Facilitator:** Michelle **Phone:** 9239 1916

**E-mail:** [Attach@unitingwa.org.au](mailto: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** | **Gender** | **Relation** |
|  |  |  |  |  |
|  |  |  |  |  |
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|  |  |  |  |  |

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:***