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| **FAMILY SUPPORT NETWORK****Please complete and email to the** [**Lead Agency**](https://www.wafsn.org.au/referral-contacts/) **located nearest to the Client.****Referral Criteria:*** Families who need assistance navigating the service system and would benefit from coordination to link into relevant services
* Families who do not have an open case with the Department of Communities
* Young people (aged 18 to 25 years old) who have been in care themselves
* Self-referrals are accepted
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| **Referrer details** |
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|  |  |
| --- | --- |
| [ ]  Department of Communities  | [ ]  Other Organisation |
| [ ]  Family Support Network  | [ ]  **Self-referral** |
| [ ]  Partner Agency | [ ]  **Other** |

 |
| Date of referral |          |
| Referrer’s name |   |
| Organisation name*(if applicable)* |   |
| Referrers contact telephone | Work |   | Mobile |   |
| Referrers email |   |
| Relationship to family |   |
| Family is aware and consents to this referral *(required)* | [ ]  Yes  |
| Open Case to Department of Communities  | [ ]  No [ ]  Yes [ ]  Unknown  |
| How did you hear about the FSN |  |
| **Client details** |
| Parent/Carer Full Name |  | D.O.B |  |
| Residential Address |   | Gender |  |
| Contact Details | Mobile |  | Email |   |
| Ethnicity  | Aboriginal TSI CALD Other  |
| Language spoken at home |   | Interpreter Required |  |
| Parent/Carer Full Name |   | D.O.B |  |
| Residential Address |  | Gender |  |
| Contact Details | Mobile |  | Email |  |
| Ethnicity | Aboriginal TSI CALD Other  |
| Language spoken at home |  | Interpreter Required |  |

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| Child 1 name  |   | D.O.B |  |
| Residential Address |  | Gender |  |
| Contact Details | Mobile |  | Email |  |
| Ethnicity | Aboriginal TSI CALD Other  |
| Language spoken at home |  | Interpreter Required |  |

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| --- | --- | --- | --- |
| Child 2 name  |   | D.O.B |  |
| Residential Address |  | Gender |  |
| Contact Details | Mobile |  | Email |  |
| Ethnicity | Aboriginal TSI CALD Other  |
| Language spoken at home |  | Interpreter Required |  |

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| --- | --- | --- | --- |
| Child 3 name  |   | D.O.B |  |
| Residential Address |  | Gender |  |
| Contact Details | Mobile |  | Email |  |
| Ethnicity | Aboriginal TSI CALD Other  |
| Language spoken at home |  | Interpreter Required |  |

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| --- | --- | --- | --- |
| Child 4 name  |   | D.O.B |  |
| Residential Address |  | Gender |  |
| Contact Details | Mobile |  | Email |  |
| Ethnicity | Aboriginal TSI CALD Other  |
| Language spoken at home |  | Interpreter Required |  |
|  |
| **Reason for referral –** please expand if required |
|   |
| **Current support services** – please include names and contact details if known |
|  |
| **Self-identified support needs –** please expand for each person or child if required |
|  |
| **Additional Details –** List any additional client/child details or other relevant information here |
|  |