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| **Referral Date:**  |  / /  | ***Please forward all referrals to*** | vaccawestkooriekidsplaygroup@vacca.org  |
| **Parent / Carer Details** |
|  |
| **Parent/carer Name:** |  | **DOB:** |  |
| **Marital Status:** |  | **Gender:** |  |
| **Relationship to Child/ren** |  |
| **Contact Number(s):** |  |
| **Best way to contact you:** |  [ ]  Phone [ ]  Email [ ]  Other:  |   |
| **Address:** |  |
|  | Street Address (include apartment/unit number, if any) Suburb, State, Postcode |

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| **Children’s Information**  |
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| **Name:** |  | **D.O.B.** |  | **Gender** |  | **Aboriginal and/ or Torres Strait Islander** |  | **Mob/Country** |
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| **Referrer Details** |
| **Name:** |  |
| **Program / Organisation:**  |  |
| **Mobile:** |  |
| **Email:** |  |

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| **Reason for Referral** |
| Click or tap here to enter text. |

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| **Do the family have their own transport?**  | [ ]  Yes [ ]  No | Click or tap here to enter text. |
| **Will the family need transport to playgroup each week?**  | [ ]  Yes [ ]  No | Click or tap here to enter text. |
| **Are the Children in out of home care? Yes / No**  | [ ]  Yes [ ]  No | Click or tap here to enter text. |
| **Is there current Child Protection involvement?** *If yes, please provide further information around there involvement* | [ ]  Yes [ ]  No | Click or tap here to enter text. |
| **Do any of the children have any disabilities / additional needs / diagnosis.** *If yes, please provide further information*  | [ ]  Yes [ ]  No | Click or tap here to enter text. |

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| **Children’s Medical Details** |
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| **Child’s Name:** |  | **Medical Issue’s, Allergies, Disability, Support Needs** |
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| **Communication** |

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| **Language(s) Spoken:** |  |
| **Literacy Support required?** | [ ]  Yes [ ]  No |  |
| **Hearing Impairment?** | [ ]  Yes [ ]  No |  |
| **Interpreter required?** | [ ]  Yes [ ]  No If **yes** please state which language:  |  |
|  |
| **Would the client like to have an advocate/support person?** (Personal or Professional) | [ ]  Yes [ ]  No  |
| If **yes**, complete information below: |
| **Name:** |  |  |
| **Relationship to Client:** |  |  |
| **Organisations:** (if applicable) |  |  |
| **Contact Number:** |  |  |

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| **Emergency Contact Person for the child (Contact must be different to the Parent/Carer completing this form)** |
|  |
| **Name:** |  |
| **Relationship to Child** |  |
| **Contact No:** |  |

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| **Professional involvement**  |

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| **How did you hear about Playgroup?** |  |
| **Are you currently involved with another VACCA program?**If so, please complete the below table | [ ]  Yes [ ]  No  |

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| **Name of worker** |  | **Program name** |  | **Organisation/Location** |  | **Contact number** |  | **Current or Previous** |
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