**Armajun Health Service Aboriginal Corporation**
Indigenous Corporation Number: 8278
**Trading as: Armajun Aboriginal Health Service**

# Family Healing: Intake and Referral Form

| **Person making referral / giving information** | | |
|---|---|---|
| Type/Service ☐ Self ☐ Medical Service ☐ FaCS ☐ Police ☐ Court ☐ Other | | |
| Service name: | Date: | |
| First name: | Surname: | |
| Phone: | Email: | |
| How did you hear about our service? | | |
| Is the person below aware you are referring them to our service? ☐ Yes ☐ No | | |
| Are you aware if the person/family below has an open case with Family & Community Services? ☐ Yes ☐ No | | |
| **Intake Information** | | |
| First name: | Middle name: | |
| Surname: | Date of Birth: | |
| Address: | | |
| | Postcode | |
| Phone 1: | Phone 2: | |
| Email: | | |
| Town & Country of Birth: | Cultural group identifying with: | |
| How many family members live in the home? | How many family members have a disability? | |
| How many parents / adults live in the home? | How many children (< 18yrs) live in the home? | |
| Emergency Contact Person's Name: | Phone: | |
| **Children in the Home** | | |
| First Name: | Surname: | Date of Birth: |
| First Name: | Surname: | Date of Birth: |
| First Name: | Surname: | Date of Birth: |
| First Name: | Surname: | Date of Birth: |
| **Personal/Family mode of Transport** | | |
| Does someone in the family drive and own a car? | | |
| Does the person/family feel comfortable using public transport? | | |

## Why are you making this referral

Factors relating to referral (tick where applicable/known)

| | | |
|---|---|---|
| ☐ Cultural Issues | ☐ Relationship Issues | ☐ Finance |
| ☐ Grief and loss | ☐ Anxiety | ☐ Depression |
| ☐ Domestic Violence | ☐ Social Isolation | ☐ Employment |
| ☐ At Risk of Homelessness | ☐ Drug and Alcohol | ☐ Accommodation |
| ☐ Language/literacy problems | ☐ Education/school attendance | ☐ Relationship difficulties with peers |
| ☐ Bullying | ☐ Court Issues | ☐ Self Harm |
| ☐ Suicide attempt | ☐ Other | |

Positive factors relating to referral (tick where applicable/known)

| | | |
|---|---|---|
| ☐ Stable family environment | ☐ Secure/supportive extended family relationships/attachments | ☐ Positive school/work environment |
| ☐ Readiness for change | ☐ Healthy coping strategies | ☐ Economic security |
| ☐ Participation in community networks | ☐ Strong support networks | ☐ Communication and social skills |
| ☐ Spiritual and/or religious identity | ☐ Strong cultural identity and pride | ☐ Access to education/services |

Comments (if applicable)

## Other Services currently providing the person/family with assistance/care (please list)

| | |
|---|---|
| ☐ | ☐ |
| ☐ | ☐ |
| ☐ | ☐ |

## Sending this Referral

Please ensure you have completed all or as much of this form as possible before sending.

Contact:
Armajun Family Healing Project Team
Phone: 02- 6721 9777
Email: Sharna - ssheather@armajun.org.au or Tabatha - tjerrard@armajun.org.au

Office Use Only

## Intake Decision

Client Intake Assessment location: Date: Time:

Domestic Violence Risk Assessment Attended ☐

Client Rating: ☐ Low ☐ Medium ☐ High ☐ Information & Referral provided

| | |
|---|---|
| ☐ Not accepted<br>Date: _____ | Why?<br>Not accepted follow up actions (please select as appropriate)<br>☐ follow up with the referrer<br>☐ follow up with person/family - provide alternate referral and information advice |

☐ Accepted into Program Commencement Date: _____