Child & Family Wellbeing Services Referral Form

The C&FWS works alongside children aged 0-18, together with their families, using a child/family centred approach, where strengths are identified and built upon to work towards goals and enhance wellbeing. Both short and long term support is available.

Service Request

Referral for the assessment of suitability for the Child and Family Wellbeing Service
Phone 1300 780 081 or email teamhealth@teamhealth.asn.au

☐ Palmerston and Litchfield Child and Family Wellbeing Service
☐ Katherine Child and Family Wellbeing Service

Child or young person's details

Full name(s):	DOB:	Gender: ☐ Male ☐ Female	Support Required ☐ Yes ☐ No
Full name(s):	DOB:	Gender: ☐ Male ☐ Female	Support Required ☐ Yes ☐ No
Full name(s):	DOB:	Gender: ☐ Male ☐ Female	Support Required ☐ Yes ☐ No
Full name(s):	DOB:	Gender: ☐ Male ☐ Female	Support Required ☐ Yes ☐ No
Current residential address:	Post Code:	Telephone/ Mobile: Email:	
Indigenous status: ☐ Aboriginal ☐ Torres Strait Islander Country of birth:	Primary language spoken:	Interpreter required: ☐ Yes ☐ No	

Family or Carers details

Name/s:	DOB:	Gender: ☐ Male ☐ Female
Address:	Post Code:	Telephone/ Mobile: Email:
Indigenous status: ☐ Aboriginal ☐ Torres Strait Islander Country of birth:	Primary language spoken:	Interpreter required: ☐ Yes ☐ No

Name of Child and reason for referral: (if extra space is required please attach a separate page).

Consent for Referral

Name of referring agency/person: ______________________________________Signed:_____________________________
Contact details (phone number and email):____

____

Participant signature (if aged 16+):_________________________Parent/Guardian signature: _________________________
Date: ______________________

Office Use

Contact made with referrer: ____Date: _____________________
Eligible for Service, if no why not: ____

____

TEAMhealth