|  |
| --- |
| Client Information Date: |
| Name: |
| Phone: |
| Email: |
| Address: |
|  |

**Initial Referral to CAPS**

**Clients receiving a service from the Child and Parent Service agree for their information to be shared with Samaritans and our funding body Department of Social Services. This information is collected so our legislative requirement can be fulfilled.**

|  |  |
| --- | --- |
| Yes | No |

Has **the client given consent for this referral?**

|  |
| --- |
| Main reason for referral |
| Other needs client may require  Educational Matters  Legal information  Centrelink Information  Kinship Groups  Childcare Information 0-12 years  Counselling Referrals |

|  |  |  |
| --- | --- | --- |
| Service details | | |
| Referrer’s Name |  | |
| Referrer’s contact information: | Phone: |  |
| Email |  |
| Days of work: |  |

Please forward to [marcia.spitzkowsky@samaritans.org.au](mailto:marcia.spitzkowsky@samaritans.org.au)