Samaritans
Compassion Integrity Justice
Child and Parenting Support Program

Referral to Kinship Care Case Manager

Referrers Details:		Date:
Name:	Agency / or self:	
Email Address:		
Phone:	Mobile:	

What are you hoping Samaritans Kinship Care may be able to support you with?

☐ Centrelink Information ☐ Kinship Groups ☐ Childcare Information 0-12 years ☐ Counselling Children/Carer
☐ Educational Matters ☐ National Disability Insurance Scheme (NDIS) ☐ Legal information

Referral Information: Background Information

Do you have court orders for the child/children in your care?

☐ Family Court ☐ Children's Court ☐ No orders

Agencies working with the family:

Agency: *Eg Department of Education*	**Worker:** *Teacher and Principal's name*	**Contact Details:** *Phone number and/or email address*

Do you give us consent to get in contact with these agencies?

Yes ☐ No ☐ Client Signature ________________________________

OR

Yes ☐ No ☐ Verbal Consent ________________________________

Is there any other information that you think we should know?

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Client consent to collect and store personal information:

Samaritans collect information to better understand the people we support. Samaritans and the funding body (DSS) use the information to improve services and to ensure we are meeting the needs of the community. All data is stored in accordance with privacy guidelines.

Yes ☐ No ☐ Client Signature____________________________________

OR

Yes ☐ No ☐ Verbal Consent ____________________________________

Client consent to participate in follow-up research:

From time to time our funding body (DSS) ask if program participants are willing to assist with follow-up research about this program. Would you be willing to be contacted by the Department of Social Services to provide further information about this program?

Yes ☐ No ☐ Client Signature____________________________________

OR

Yes ☐ No ☐ Verbal Consent ____________________________________

Family / Client Details:		
Name:	Gender:	DOB:
Address:		Postcode:
Email address:	Phone / Mobile:	
Would you like to be kept up to date by email about other groups we run? Y / N		
Aboriginal / Torres Strait Islander	Country of birth:	
Main Language:	Interpreter Required? Y / N	Disability and or medical condition?

Current Partner Details:		
Name:	Gender:	DOB:
Address:		Postcode:
Email address:	Phone / Mobile:	
Aboriginal / Torres Strait Islander?	Country of birth:	
Main Language:	Interpreter Required? Y / N	Disability and or medical condition?

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Child/ren's Details:		**Relationship to Carer:**	
Name:		Gender:	DOB:
Aboriginal / Torres Strait Islander?	Country of birth:		
Main language:	Any disability/medical condition/allergies Y/N	Please list	
Child/ren's Details:		**Relationship to Carer:**	
Name:		Gender:	DOB:
Aboriginal / Torres Strait Islander?	Country of birth:		
Main language:	Any disability/medical condition/allergies Y/N	Please list	
Child/ren's Details:		**Relationship to Carer:**	
Name:		Gender:	DOB:
Aboriginal / Torres Strait Islander?	Country of birth:		
Main language:	Any disability/medical condition/allergies Y/N	Please list	
Child/ren's Details:		**Relationship to Carer:**	
Name:		Gender:	DOB:
Aboriginal / Torres Strait Islander?	Country of birth:		
Main language:	Any disability/medical condition/allergies Y/N	Please list	
Child/ren's Details:		**Relationship to Carer:**	
Name:		Gender:	DOB:
Aboriginal / Torres Strait Islander?	Country of birth:		
Main language:	Any disability/medical condition/allergies Y/N	Please list	
Child/ren's Details:		**Relationship to Carer:**	
Name:		Gender:	DOB:
Aboriginal / Torres Strait Islander?	Country of birth:		
Main language:	Any disability/medical condition/allergies Y/N	Please list	

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Office Use Only: DSS Data			
Client Name	Client ID	Case ID	Entered
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Data entered by: ______________________________ **Date:** ___________________________________