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|   | **VICTORIAN ABORIGINAL HEALTH SERVICE CO-OPERATIVE LTD.**ABN 51 825 578 859186 Nicholson St, Fitzroy, Victoria 3065 Ph: (03) 9419 3000 extension  |

**INTAKE FORM TO VAHS**

**FOR FAMILIES OR PROFESSIONALS INVOLVED IN**

**HEALTH AND WELLBEING OF CHILDREN AND YOUNG PEOPLE**

**Please email referral to: paediatricreferrals@vahs.org.au**

**Date of referral** ­­­­

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| **CLIENT DETAILS Aboriginal** [ ]  **Torres Strait Is** [ ]  **Both** [ ] **Family Name** ­­­ **Given Name(s)**  **Other Name(s) / Preferred Name(s**) ­­­ **DOB:**Click or tap to enter a date. **Gender**: Choose an item.**Current Address:** **Suburb** **P/Code** **Phone** **Mobile**  |

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| **REFERRER DETAILS (if not a parent/carer)****Name:** **Position:** **Service/Agency:** **Address:**   **Suburb:** **P/Code** **Phone:** **Preferred contact**: Choose an item.**Email Address**:  |
| **PARENT 1** [ ] **Aboriginal** [ ] **Torres Strait Is** [ ]  **Both Name:** **Address:**  **Suburb:**  **P/Code:**  **Ph Home:** **Ph Mobile:** **Email (optional):**  | **PARENT 2** [ ] **Aboriginal** [ ] **Torres Strait Is** [ ]  **Both** [ ]  **Name:** **Address:** **Suburb:**  **P/Code:** **Ph Home:** **Ph Mobile:** **Email (optional):**  |
| **LEGAL GUARDIAN** **Who is the child’s legal guardian?** [ ]  Mother [ ]  Father [ ]  Both [ ]  Other **If other, Relationship:**  **Name:** **Ph Home:**  **Ph Mobile:** **Email:**  |

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| **COURT ORDERS IN PLACE****Are there any court orders in place in relation to this child**: Yes [ ]  No [ ]  If yes, **Type of order:** **Order Expiry date:** Click or tap to enter a date. **Relevant details of order:**   |

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| A**UTHORITY TO CONSENT TO MEDICAL CARE****Who is authorised to provide consent for medical care and procedures for this child?**Parent [ ]  Delegated [ ]  I**f delegated, who is the delegated person:** Name: Position: Service/Agency: Address: Suburb: P/Code: Direct phone: Mobile: **Preferred contact**: Choose an item.Email Address:  |

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| **CONSENT TO CONTACT REFERRER AND OTHER AGENCIES INVOLVED CHILD’S CARE****As the authorised representative of this child, I consent to a referral to the Victorian Aboriginal Health Service (VAHS) for a health assessment and to subsequent referral, management and treatment determined as necessary by the assessment.****I give permission for VAHS Intake to contact the referrer and other agencies listed below involved in my child’s care** **Name:** **Date:** **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship:**   |

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| **PRIMARY OR ALTERNATIVE CONTACT PERSON FOR THIS CLIENT (IF DIFFERENT TO LEGAL GUARDIAN)** (e.g. if VAHS wished to arrange an appointment)**Name** **:** **Relationship:** **Service/Agency (if applicable):** **Address:**  **Suburb:** **P/Code:** **Direct phone:** **Mobile:** **Preferred contact:**  **Email Address:**   |

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| **WHO DOES THE CHILD LIVE WITH AT CURRENT RESIDENTIAL ADDRESS** **Name:**  [ ]  **Mother** [ ]  **Father** [ ]  **Sibling** [ ]  **Other\***  **DOB:**  [ ]  **M** [ ]  **F** **Name:**  [ ]  **Mother** [ ]  **Father** [ ]  **Sibling** [ ]  **Other\***  **DOB:**  [ ]  **M** [ ]  **F** **Name:**  [ ]  **Mother** [ ]  **Father** [ ]  **Sibling** [ ]  **Other\***  **DOB:**  [ ]  **M** [ ]  **F** **Name:**  [ ]  **Mother** [ ]  **Father** [ ]  **Sibling** [ ]  **Other\***  **DOB:**  [ ]  **M** [ ]  **F** **Name:**  [ ]  **Mother** [ ]  **Father** [ ]  **Sibling** [ ]  **Other\***  **DOB:**  [ ]  **M** [ ]  **F** **Name:**  [ ]  **Mother** [ ]  **Father** [ ]  **Sibling** [ ]  **Other\***  **DOB:**  [ ]  **M** [ ]  **F** **Name:**  [ ]  **Mother** [ ]  **Father** [ ]  **Sibling** [ ]  **Other\***  **DOB:**  [ ]  **M** [ ]  **F** **Name:**  [ ]  **Mother** [ ]  **Father** [ ]  **Sibling** [ ]  **Other\***  **DOB:**  [ ]  **M** [ ]  **F** **\*IF OTHER PLEASE STATE RELATIONSHIP** |

**DOES THE CHILD LIVE WITH ANOTHER FAMILY MEMBER OR CARER REGULARLY**

[ ]  Yes [ ]  No If yes, please provide details

**Name:**  [ ]  **Mother** [ ]  **Father** [ ] **Other**  [ ]  **Aboriginal** [ ]  **Torres Strait Is** [ ]  **Both**

**Address:**   **Suburb:**   **P/Code:**

**Ph Home:**   **Ph Mobile:**

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| **SIGNIFICANT OTHER PERSON INVOLVED IN CHILD’S CARE****e.g. Grand-mother/father/Aunt/Uncle/Other** [ ] **Aboriginal** [ ] **Torres Strait Is** [ ]  **Both** **Name:** **Address:**  **Suburb:**  **P/Code:**  **Ph Home:** **Ph Mobile:** **Email (optional):**  | **SIGNIFICANT OTHER PERSON INVOLVED IN CHILD’S CARE****e.g. Grand-mother/father/Aunt/Uncle/Other** [ ] **Aboriginal** [ ] **Torres Strait Is** [ ]  **Both** **Name:** **Address:**  **Suburb:**  **P/Code:**  **Ph Home:** **Ph Mobile:** **Email (optional):**  |

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| **PROFESSIONALS / AGENCIES / SERVICE PROVIDERS INVOLVED** |
| **Name:** **Position:** **Service/Agency:** **Phone:** **Email Address**:  | **Name:** **Position:** **Service/Agency:** **Phone:** **Email Address**:  |
| **Name:** **Position:** **Service/Agency:** **Phone:** **Email Address**:  | **Name:** **Position:** **Service/Agency:** **Phone:** **Email Address**:  |

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| **SCHOOL / KINDERGARTEN / CHILD CARE** **Does the client go to school / kindergarten / childcare?** [ ]  Yes [ ]  No **Name of School / Kindergarten / Child Care:** **Grade / Year (if applicable):** **Address:** **Suburb:** **P/Code:** **Contact Person:** **Ph** **Work:** **Ph Mobile:** **Email:**  |

**REASON FOR REFERRAL**

*VAHS offers many services to Children and Young People. To provide the client with the most appropriate service, it is useful for VAHS to know your specific concerns in regards to the client’s health and or development.*

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| **DO YOU HAVE A SPECIFIC CONCERN(S) REGARDING THE CLIENT’S HEALTH OR WELLBEING THAT YOU WISH VAHS TO ASSESS OR ADDRESS?**   |

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| **OTHER SPECIFIC CONCERNS****Are you concerned about any of the following (tick all appropriate)**[ ]  Motor Development (e.g. rolling, crawling, walking) [ ]  Speech Development [ ]  Hearing [ ]  Behaviour [ ]  Learning [ ]  Intellectual Disability [ ]  Mental Health (Specify: )[ ]  Immunisation [ ]  Dental Health [ ]  Drug and Alcohol issues [ ]  Puberty [ ]  Sexual and Reproductive health |

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| **PAST MEDICAL HISTORY** **Does the Client have any medical diagnosis or condition that you know of?** [ ]  Yes [ ]  No**If yes, please list below including any previous assessments the provider name and service:**  |

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| **MEDICATION** **Is the Client currently on any medication?** [ ]  Yes [ ]  No If yes, please list below (including dose):   |

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| **OTHER SUPPORT THAT COULD POSSIBLY BE PROVED TO FAMILY BY VAHS** VAHS offers a number of services. Do you think this family / parent / carer could also benefit from support from[ ]  Parenting support [ ]  Family counselling [ ]  Men’s Group[ ]  Financial Counselling [ ]  Healthy Lifestyles [ ]  Drug and alcohol services[ ]  Mental health for adults  |

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| **OTHER INFORMATION** **Is there any other information that you think is important for us to know about this client or family?**  |

**PLEASE PROVIDE COPIES OF ANY DOCUMENTATION, PREVIOUS ASSESSMENTS, SCHOOL REPORTS ETC. THAT MAY ASSIST IN PROVIDING CARE FOR THIS CLIENT**