WOMEN *helping* WOMEN

Referral / Intake Form

N.B *Client **MUST** be pregnant and check **2** or more positive factors in **2** or more criteria areas.*

NAME: _____

ADDRESS: _____

PHONE: _____

DATE of referral: ____/____/_____ **Due Date** ____/____/_____

Referral Agency/Person _____

AGE:_____(**under 16 = 2 factors**) **D.O.B** __/__/_____(There is **NO** age limit on our service)

CLIENT CRITERIA

DESCENT: ☐ Aboriginal ☐ Torres Strait Islander ☐ Other _____

FINANCIAL: ☐ Centrelink Benefit Benefit Type _____

☐ HealthCare Card

☐ Low Annual Income $_____(please give approx. amount)

EDUCATION: ☐ Less than High School ☐ HSC ☐ Tertiary ☐ Support (Special) School

RESIDENCE: ☐ Homeless ☐ At risk of homelessness

☐ Supported tenancy

Women's Shelter Family Violence -

PREGNANCY:

☐ Unplanned/crisis pregnancy

☐ Pre-natal diagnosis ☐ suspecting / confirming baby has a disability/medical problems

☐ Previous history of pregnancy complications _____

☐ Previous history of still born/miscarriages/abortion

☐ Medical condition relating to pregnancy _____

ESTHERS AUSTRALIA LTD.
www.esthersaustralia.com.au
info@esthersaustralia.com.au
0479 055 777
P.O Box 6058 Meridan Plains, QLD, 455
HOBART, TAS| CALOUNDRA, QLD

PHYSICAL: ☐ Disability (please specify) _____

☐ Alcohol/drug use

☐ Present or past eating disorders

EMOTIONAL: ☐ Present or previous history of peri-natal depression

☐ Present or past Mental Health issues _____
Please give details

☐ Present or past suicide ideation

If yes to any of the above please give details

_____

_____

_____

_____

_____

OB/GYN _____

Phone:

If none, where has client been referred? _____

MEDICATION ___ if yes please list medication, reason for medication and prescribing doctors details _____

_____

G.P. NAME _____

Address _____

Phone _____

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SPECIALIST _____
(please add area of specialisation psych/endo/physio etc**)**

SUPPORT: ☐ Single and/or no involvement by baby's father

☐ No family support

☐ Present or past history of family violence/abuse (regardless of answer - do you feel safe?)

CHILD SAFETY INVOLVEMENT ☐ **BABY ALERT** ☐

If yes please give more details

_____

_____

_____

_____

_____

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REFERRING AGENCY _____

Is referring agency continuing with support? ☐

Is follow up required by referring agency? ☐

If Yes: Has referring agency received consent from client to share information with our service?
Yes/No/Don't know (if latter please follow up)

Contact Details:

Referrer _____Position _____

Phone _____ Email _____

Further Comments to support referral

_____
_____
_____
_____
_____
_____

OFFICE USE ONLY

Assessment Completed ___/____/_____

Allocated ___/____/_____

Data entered ___/____/_____

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