Family Team Client Intake Form

Referral Details:

How did the family hear about the service: ☐ Self ☐ Internal ☐ External **please provide details below**

Name of Service:		**Phone**	**Referral Date:**
Name of Worker:		**Email:**	

Client Consent: Have you received consent from the client to provide their personal information to Metro Assist.
☐ YES ☐ NO **Is this an emergency?** *Does Metro Assist require to follow up within 24hours* ☐ YES ☐ NO

CLIENT/ APPLICANT DETAILS: **Client Number:**

First name:		**Surname:**	
Address	Street Address:		
	Suburb:	Postcode	State
Phone Preferred type of contact please tick	Home: ☐	Mobile: ☐	Work: ☐
Email:		**Date of Birth:**	**Age:**
Gender: ☐ F ☐M ☐Other		**Do you Identity as Aboriginal or Torres Strait Islander?** YES No	
Country of Birth:		**Language spoken at home:**	
Do you have a disability: ☐ YES ☐NO		**Interpreter Required:** ☐ YES ☐NO	

Current Visa Status: ☐ Student Visa ☐ Bridging Visa ☐ Tourist/ Travel visa ☐Non Permanent visa
Please tick ☐Australian Citizen / Resident ☐ Spousal Visa ☐ Other.....

Source of income:	**Occupation:**	
Marital Status:	**Spouse Name** (optional)**:**	**Contact Details** (optional)**:**

Family Details:

Are you a first time parent ☐YES ☐ NO

Dose any of you children have a disability:
☐YES ☐ NO

What is your relationship to the children you care for:
☐ Mother ☐ Father ☐Grandparents ☐ Foster Carer ☐ Other_____
☐ Sole Parent

Child's Name	Place of Birth	Date of Birth	Age	Gender
				☐ Male ☐ Female
				☐ Male ☐ Female
				☐ Male ☐ Female
				☐ Male ☐ Female
				☐ Male ☐ Female

Presenting Need(s):

Please Email or Fax completed form to: familyservices@metroassist.org.au or 97981717

Office Use Only

Program allocation: ☐ **EIPP** ☐ **IWFC** ☐ **Other** _____

Date of initial contact:_____ **Date of final contact:**_____

Assigned Casework Name:_____ **Caseworker Signature:** _____