Strengthening Family Connections

Livingstone Shire Council

# REQUEST FOR SERVICE FORM

**Enquiries:** 07 4913 3830 **Email:** SFC@livingstone.qld.gov.au **Address:** 35 William Street, Yeppoon QLD 4703

**PRIVACY NOTICE**

Livingstone Shire Council is collecting the personal information you supply on this form for the purpose of assessing the suitability of the referral of an individual or family to access services provided by Strengthening Family Connections (SFC). The Council is authorised to do this under the Information Privacy Act 2009. Your personal details will not be disclosed to any other person or agency external to SFC without your consent unless required or authorised by law.

**PLEASE NOTE**: SFC is funded to work with children, young people (unborn to 18yrs) and their families who are in vulnerable situations. Family support and case management services are offered to families who reside on the **Capricorn Coast** and are not currently subject to statutory child protection intervention. SFC can work with families who are at risk of entering or re-entering the Child Safety System. *

***Please note SFC provide family support and case management we are not solely a counselling service.**

**It is our policy to arrange an initial meeting with you to discuss your needs and to determine whether we are the most appropriate organisation to offer support and assistance for your family.**

| **Date of Referral** | |
|---|---|

| **Primary Client Details** | | | | | | | |
|---|---|---|---|---|---|---|---|
| First Name | | | | Surname | | | |
| Date of Birth | | Gender Identity | | Preferred Name Preferred Pronoun | | | |
| Phone | | | Email | | | | |
| Address | | | | | | | |
| City | | | State | | Postcode | | |
| Postal Address *(if applicable)* | | | | | | | |
| **Name of Primary Contact *(if client under 18)*** | | | | **Contact No.** | | | |

| **IMPORTANT** | | |
|---|---|---|
| **Is it safe for SFC to contact you via phone/text for appointments, send out letters on occasions?** | ☐ **Yes** | ☐ **NO** |
| If **NO;** restricted communication is required – Client Consent for Communication Form MUST be completed & sent to Admin | ☐ | |

| **Family Members** | | | | |
|---|---|---|---|---|
| **First Name** | **Last Name** | **Relationship to Client** | **DOB** | **Gender Identity** |
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| Reason for Referral |
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| |

| Please list Medical / Allied Health Services who have been / are involved with you / your family: |
|---|
| |

| Demographic Information | | | | |
|---|---|---|---|---|
| Country of Birth | | Do you require an interpreter? | ❑ Yes | ❑ No |
| Language at home | | Do you require an Auslan interpreter? | ❑ Yes | ❑ No |
| Do any family members identify as | | Aboriginal / Torres Strait Islander? | ❑ Yes | ❑ No |
| | | Culturally and Linguistically Diverse? | ❑ Yes | ❑ No |

| Is there any Family Court Involvement ❑ Yes ❑ No |
|---|

| Client Consent | | | |
|---|---|---|---|
| **Signature of Primary Client / Primary Contact** | | **Date** | |
| | | | |
| *Only if referred by an Agency please complete:* | | | |
| I consent for Strengthening Family Connections to provide information about the progress / outcome of my referral to the below referring agency. **Please mark the correct box ☐ Yes ☐ No** | | | |

| Agency Referral | | | | |
|---|---|---|---|---|
| Referring Agency | | | | |
| Postal Address | | | Phone | |
| Referrer's Name | | Email | | |
| Signature of Referring Person | | | Date | |

**Please return completed form to the SFC office at 35 William Street, Yeppoon**
**Alternatively, email through to our confidential mailbox - SFC@livingstone.qld.gov.au**

| OFFICE USE ONLY | Client Referral assessed as eligible? | ❑ Yes | ❑ No | ❑ Not applicable |
|---|---|---|---|---|
| Notes: | | | | |
| | | | | |