

**THE FAMILY INCLUSION NETWORK OF
WESTERN AUSTRALIA INC.**



REQUEST FOR ASSISTANCE FORM

The Family Inclusion Network of WA provides services for parents or family members with children in care or at risk of being placed in care. If you require services or you have a client you want to refer, please complete this form.

FAMILY DETAILS		
Surname:	Telephone:	
First Name:	Mobile:	
Address/Postal Address:	Email:	
	Ethnicity: <i>(Optional)</i>	
Post Code:	Religion: <i>(Optional)</i>	
Were you a child raised in care? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Please list the names of children, their DOB, and what Care & Protection orders are in place <i>(if any)</i> : <i>(Please include children's surname if different from your own) (Orders can be Interim, Supervision, 2 year or 18 years)</i>		
Name:	DOB:	Order in Place:
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REFERRAL SOURCE		
Who is making this referral? Name: _____ :		
<input type="checkbox"/> Self Referral <i>Where did you hear about us?.....</i>		
<input type="checkbox"/> Family or Friend	<input type="checkbox"/> Health worker (e.g., hospital, GP, Child Health Nurse, Mental Health)	
<input type="checkbox"/> DCP (eg. Case Worker, Child Advocate)	<input type="checkbox"/> Community Services or Agency	
<input type="checkbox"/> Other Government Dept (eg. Prison, Centrelink, Other)	<input type="checkbox"/> Other (specify): _____	
Reason for assistance?		
DCP office the case is open to:		Case Workers Name:
Team Leader:	Legal Representative: <input type="checkbox"/> Yes <input type="checkbox"/> No	

OFFICE USE ONLY	
Date Received: : _____	
Phone Advice Only <input type="checkbox"/>	Time Taken: _____
Request for Assistance <input type="checkbox"/>	
Immediate Response Provided: Y/N By: _____ On: _____ Purpose: _____	
Case Allocated to: _____ On: _____	

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