HUNTER NEW ENGLAND LOCAL HEALTH DISTRICT

Facility: _____

FAMILY CARE COTTAGE INTAKE REFERRAL FORM

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. ____ / ____ / ____	M.O.
ADDRESS	
LOCATION / WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

HNEMR312

HNE281625

BINDING MARGIN – DO NOT WRITE

Complete both pages and fax to 4932 0097 or email HNELHD-MaitlandFamilyCare@health.nsw.gov.au

PARENT / CARER DETAILS:	REFERRER DETAILS
MRN: _____	*Date:* _____
Surname: _____	*Name:* _____
Given Names: _____	*Agency / Service:* _____
Address: _____	_____
_____	*Address:* _____
_____	_____
DOB: _____	_____
Phone No: _____	*Phone No:* _____
Partner's Name: _____	*GP:* _____
Partner's Contact No: _____	

REFERRED INFANT / CHILD	SIBLINGS	AGE
MRN: _____	_____	_____
Surname: _____	_____	_____
Given Names: _____	_____	_____
DOB: _____	_____	_____

DESCRIPTION OF CURRENT ISSUE (SITUATION):

Is the client aware of the referral? ☐ Yes ☐ No

How long has the issue been a concern?

FAMILY CARE COTTAGE INTAKE REFERRAL FORM

Maternity

050620

HUNTER NEW ENGLAND LOCAL HEALTH DISTRICT

Facility: _____

FAMILY CARE COTTAGE INTAKE REFERRAL FORM

HNE281625

Mantatory - Name / Sex / DOB	
FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. ____ / ____ / ____	M.O.
ADDRESS	
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

***** To be completed by Referrer*****

- ***Social Issues and / or stressors (background):***

- ***Present Management Plan:***

- ***Mental Heath:***

EDS (*Please attach if available)* Score _____ Date / / Q10 _____

Current mental health concerns:

- ***Past mental health concerns:***

- ***Concerns about parent – infant relationship (assessment):***

- ***Referrer Recommendations:***

Print Name **Signature** **Date** / /

FOR FCC STAFF USE ONLY:	*Referral Accepted* ☐ Yes ☐ No *(reason)*

Allocated to:	*Date Allocated:*	*Date Contacted:*	*Date Contacted:*	*Date Contacted:*	*Date Contacted:*

Appointment	Home Visit (Risk Assessment)	Day Stay

BINDING MARGIN – DO NOT WRITE