HUNTER NEW ENGLAND LOCAL HEALTH DISTRICT

Facility: ______________________________

FAMILY CARE COTTAGE INTAKE REFERRAL FORM

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

HNEMR312

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: ______________________	

BINDING MARGIN – DO NOT WRITE

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

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	

HUNTER NEW ENGLAND LOCAL HEALTH DISTRICT

Facility: ______________________

FAMILY CARE COTTAGE INTAKE REFERRAL FORM

HNE281625

***** 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