

## PRESCHOOL FIELD OFFICER REFERRAL FORM

**TO ACCESS THIS SERVICE CHILDREN MUST HAVE TURNED**

**3 YEARS OF AGE BEFORE 30 APRIL 2018**

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| **ALL SECTIONS OF THIS FORM MUST BE COMPLETED IN FULL BY THE EDUCATOR AND PARENT/GUARDIAN** |

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| **CHILD’S DETAILS** | | | | | | | | | | | | | |
| Child’s Name: |  | | | | | | | | | | | | |
| Date of Birth: |  | | | |  | | Gender: | | | | 🞏 Male 🞏 Female | | |
| Home Address: |  | | | | Suburb: | |  | | | | Postcode: | |  |
| Is the child: | 🞏 Aboriginal | | 🞏 Torres Strait Islander | | | | | | 🞏 Both Aboriginal and Torres Strait Islander | | | | |
| Country of Birth: |  | | | | | Language(s) spoken at home: | | | |  | | | |
| Proficiency Spoken English: | | 🞏 Very Well | | 🞏 Well | | | | 🞏 Not Well | | | | 🞏 Not at all | |

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| **PARENT/GUARDIAN DETAILS** | | | | | | | | | | | |
| Child lives with: | | 🞏 Both parents | | 🞏 Mother | | | | 🞏 Father | | Other \_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Carer 1** | Name: |  |  | | | DOB: | | | Relationship to Child: | |  |
| Phone | Home: |  | | | Work: | |  | | Mobile: | |  |
| Email: |  | | | | | Preferred  Language: | | | Country of  Birth: | | |
| **Carer 2** | Name: |  | | | | DOB: | | | Relationship to Child: | |  |
| Phone | Home: |  | | | Work: | |  | | Mobile: | |  |
| Email: |  | | | | | Preferred  Language: | | | Country of  Birth: | | |

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| If the family arrived in Australia from overseas, please supply year of arrival: |  | |
| Who is the best person to contact in regards to this referral? |  | |
| Do you require the use of an interpreter? | 🞏 Yes | 🞏 No |
| Is this the child’s second year of funded 4 year old Kindergarten? | 🞏 Yes | 🞏 No |
| Has the child had their 3 1/2 year old Maternal Child Health check? | 🞏 Yes | 🞏 No |
| Does your child attend any other early years’ service, e.g. long day care or family day care | 🞏 Yes | 🞏 No |
| If Yes, where and when? | | |
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| **SIBLINGS** | | | | | | | |
| **SIBLING 1** | | **SIBLING 2** | | **SIBLING 3** | | **SIBLING 4** | |
| Name: |  | Name: |  | Name: |  | Name: |  |
| Gender: | □ Male □ Female | Gender: | □ Male □ Female | Gender: | □ Male □ Female | Gender: | □ Male □ Female |
| D.O.B: |  | D.O.B: |  | D.O.B: |  | D.O.B: |  |

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| Is the parent/guardian in receipt of the Carer Allowance? | ❑ Yes ❑ No |
| Does your child have a diagnosis or undergoing assessment? | ❑ Yes ❑ No |
| If Yes, please provide details | |
| Is your child currently receiving Early Childhood Intervention Services (ECIS) or NDIS Services? (If Yes, please note PSFO Services are not available to children who are already receiving EI Services) | ❑ Yes ❑ No |
| Is your child currently on the Early Intervention Waiting List? | ❑ Yes ❑ No |

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| **Other services the child has been receiving or has been referred to – please provide information below and attach relevant reports.** | | |
| Services | Name of Agency | Name of  Professional |
| Speech Therapist |  |  |
| Paediatrician |  |  |
| Psychologist |  |  |
| Occupational Therapist |  |  |
| **Contact will be made with the listed agencies (where appropriate) to assist in developing consistent strategies. If you do not wish these services to be contacted, please tick here** ❑ | | |

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| **PARENT TO COMPLETE** | | | |
| **What are your child’s strengths?** | | | |
| **What would you like to happen for your child over the next 12 months?** | | | |
| **What do you think your child needs support with?** | | | |
| **Is there anything occurring in your family now that may be impacting on your child?** | | | |
| **Parent/Guardian level of concern (please tick)** | | | |
| **🞏 Not Concerned** | **🞏 A Little Concerned** | **🞏 Very Concerned** | **🞏 Extremely Concerned** |

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| **SERVICE INFORMATION** | | | | | | | | | | | | | |
| Name of Centre: | |  | | | | | Phone: |  | | | | | |
| Address: | |  | | | | | Suburb: |  | | | Postcode: | |  |
| Early Childhood Educator’s Name: | |  | | | | | Signature: | |  | | | | |
| Assistant 1 (if appropriate): | | | | | | |  | |  | | | | |
| Assistant 2 (if appropriate): | | | | | | |  | |  | | | | |
| Centre/Early Childhood Educator’s work email: | | | | |  | | | | | | | | |
| **Please provide child’s attendance times for each day (e.g. 8.30am to 12.30pm)** | | | | | | | | | | | | | |
|  | *Example* | | Monday | Tuesday | | Wednesday | | | | Thursday | | Friday | |
| Start | *9.00* | |  |  | |  | | | |  | |  | |
| End | *3.30* | |  |  | |  | | | |  | |  | |
| Group Name/Colour | | |  | | | | | | | | | | |
| Educator Days/Planning time | | |  | | | | | | | | | | |
| Please tell us the best day and time of the week to contact you to discuss this referral | | | | | | | | | |  | | | |
| Is this child attending your funded 4 year old program? | | | | | | | | | | **🞏** Yes | | **🞏** No | |
| Have you utilised the Preschool Field Officer Service before for this child? | | | | | | | | | | **🞏** Yes | | **🞏** No | |

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| **REFERRAL INFORMATION** | | | |
| Please select one of the following options to indicate your reason for referral | | | |
| **🞏** | **4 Year Old Service** | **🞏** | **3 Year Old Service** |

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| **EARLY CHILDHOOD EDUCATOR TO COMPLETE (please attach additional pages if needed)** | | | | |
| **DEVELOPMENTAL & LEARNING AREA** | **STRENGTHS**  Please tell us about the child’s strengths and what she/he enjoys participating in. | **CONCERNS**  Describe the concerns regarding the child’s learning, development and engagement within the early childhood environment. | **IMPACT**  Describe how this impacts on the child’s engagement within the early childhood environment | **MODIFICATIONS**  How are you currently supporting the child’s inclusion and participation in the programme? |
| **WELLBEING**  Recognise and communicate self-help needs. Regulating emotions, separation anxiety. |  |  |  |  |
| **COMMUNITY**  Building social connections and participating in reciprocal relationships. |  |  |  |  |
| **COMMUNICATION**  Verbal and non-verbal communication. |  |  |  |  |

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|  | **STRENGTHS**  Please tell us about the child’s strengths and what she/he enjoys participating in. | **CONCERNS**  Describe the concerns regarding the child’s learning, development and engagement within the early childhood environment. | **IMPACT**  Describe how this impacts on the child’s engagement within the early childhood environment | **MODIFICATIONS**  How are you currently supporting the child’s inclusion and participation in the programme? |
| **IDENTITY**  Working collaboratively with others, initiating and joining in play. |  |  |  |  |
| **LEARNING**  Sensory and physical needs, curious, enthusiastic and interested in learning environment. |  |  |  |  |
| **OTHER** |  |  |  |  |

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| **Have you read/referred to the Referral Decision Aid flowchart?** | | | | **🞏** Yes | **🞏** No |
| **Have you completed the EarlyABLES online tool to gain inclusive strategy ideas?** | | | | **🞏** Yes | **🞏** No |
| **Please indicate what you require support with** | | | | | |
| ❑ | Child observation | ❑ | Educator mentoring | | |
| ❑ | Support with referral pathways | ❑ | Resources | | |
| ❑ | Communicating with parent(s) | ❑ | Strategies | | |
| ❑ Typical vs atypical early childhood development | | | | | |

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| **The child’s voice – (For the Early Childhood Educator to complete in consultation with the child)** | |
|  | **I feel happy when:** |
|  | **I feel sad when:** |
|  | **I like:** |
|  | **I don’t like:** |
| **My friends are:** | |

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| **If the referral was not made by the child’s Early Childhood Educator, please complete the below** | | | |
| Agency Name: |  | Phone: |  |
| Contact Name: |  | Email: |  |
| Signature: |  | Date: |  |

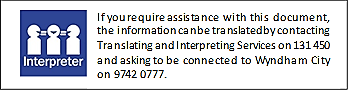
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| **CONSENT OF PARENT/GUARDIAN** | | | | | |
| * We/I have read the information above and consent to its collection and to the referral of my child to the Preschool Field Officer   Service | | | | | |
| * My/our child’s Educator has discussed with me/us their concerns and the reason for this referral | | | | | |
| * We/I have received a copy of this referral form | | | | | |
| * We/I understand that either parent/guardian(s) named on page 1 of this form can be contacted with regards to this referral if required | | | | | |
| * Wyndham City Council is bound by the *Privacy and Data Protection Act* 2014 and the *Health Records Act* 2001.  •Your consent is required for the collection and use of your personal and/or health information and that of your child. •The information is being collected by Council for the purpose of delivering services to your child by the PSFO Service; it will be used by Council and it may be shared with educators, early intervention, health and welfare service providers for the purposes mentioned.    •Your information will be stored in Council’s Customer Database and used to identify you when communicating with Council and for Council to deliver services and information to you.  •Disclosure of information may occur to other persons or agencies with consent by both parents; or the authorised parent/guardian; or as permitted by law.    •For further information on how your personal and health information will be handled, see Council’s Privacy Policy on its website. •Authorised parents and guardians may apply for access and/or amendment of the information by writing to Council’s Privacy Officer. | | | | | |
|  | | | | | |
| Parent/Guardian Signature |  | Print Name |  | Date |  |
| Parent/Guardian Signature |  | Print Name |  | Date |  |

**Please contact the Wyndham City PSFO Service on 9742 8199 if you have any questions about this form.**

**Send completed forms by email to: psfo.service@wyndham.vic.gov.au**

**Or post to:**

**PSFO Administration, Wyndham City, PO Box 197, Werribee VIC 3030, together with any supporting documentation.**



**OFFICE USE ONLY**Date Rec: Client Code: □ Checked by Intake

Confirmation letter date: NAR: Service Family