Family and Parent Peer Support Participant Application Form

Mental Illness Fellowship of WA
PO Box 1947
Midland DC, WA, 6936
Tel: 9237 8900
Web: www.mifwa.org.au

Referral Date:

Please Complete All Sections
Please complete all details with Participant (please print). Post or E mail to the address above or to angie.gallagher@mifwa.org.au

Personal Details (please include details of each family member)				
	Last Name	First Name	Date of Birth	Sex
Parent 1				
Parent 2				
Child 1				
Child 2				
Child 3				
Child 4				
Child 5				
Child 6				
Others involved with the family (Not including service workers)				

Contact Numbers:	Address Including Postcode:

Aboriginal or Torres Straight Inslander: Yes No	Sex: Male
CALD: Yes No Country of Origin:	Female

Emergency Contacts		
Name:	Relationship:	Contact No:
Name:	Relationship:	Contact No:

Details of Mental Health Care Professional Involved		
Name:	Hospital/ Clinic:	Contact No:
Mental Health Concerns:		
Has there been any involvement with The Department of Child Protection and Family Support? If so, when and what service did they provide?		
Is the Participant Involved With Any Other Health Care Professionals/ Services?(eg,GP,Ruah,COPMI)		

Background Information
Purpose of Referral:
Expectations of The Program- What Would You/ The Participant Like To Achieve?

Is There Any Other Information That Will Help Us Understand How We Can Assist You With Your Support?

Have You/ The Participant Had Any Previous Experiences With Any Of The Following:
Substance Abuse: Yes No Comments:
Self Harm: Yes No Comments:
Violence/ Aggression: Yes No Comments:
Do You Have Any Medical Alerts (e.g. Epilepsy, Diabetes, Hep C etc):

Family and Parent Peer Support Services	
What Type Of Support Would You/ The Participant Benefit From The Most? (Tick All Relevant Areas)	
Psychosocial/ Health &Recreation	Family Support
Managing Budget/ Accomodation	Family Communication
Stress Management & Relaxation	Family Routines
Independent Living Skills	Parenting Strategies
Identifying & Using Community Facilities	Liaison with School/ DCPFS etc
Employment/ Educational Support	Behaviour and consequences
Fitness	Info and Support for Children
Walking Group/ Social Groups/ Sport & Recreation	Respite
Others- Please Specify:	
We are able to offer support from a Family Support Worker and a Parent Peer Worker, Please specify which you would prefer: Family Support Parent Peer Both	
Other General Comments (Level of Insight, intention to engage etc)	

Referral Completed By:		
Name:	Title, Qualification:	Clinic/ Hospital and Postal Address:
Contact Number:	E mail:	Self Referral/ Referrer Signature:
Following acceptance of this referral, a comprehensive Needs Assessment will be arranged to ascertain suitability for the program.		