

Macarthur Gateway Resource Service – Client Intake Form

Date: ____/____/____

Self referral: Yes No

Referring
Agency: _____

Mandatory Reporting: Workers of this service are required by law to report concerns for the safety of children and young persons to Family and Community Services (FaCS).

We only report when information given to us by you or your children indicates that your child/ren are at significant risk of harm. If we become aware that your children maybe at significant risk of harm and we are considering making a report we will make every effort to discuss our concerns with before making the report.

Confidentiality: What you say to us does stay with us we don't pass on any information without your permission, but there are circumstances when we would need to talk to or contact an outside service without your permission. For example if you were harming yourself, harming someone else or someone else was harming you or if you have been reported as a missing person or if we know that you have been involved in a serious crime.

Client Details		
Given Name	Surname	Other Names/aliases/preferred
Are you in immediate danger? <input type="checkbox"/> No <input type="checkbox"/> Yes		
Do you have any immediate needs, medical, accomodation, food etc? <input type="checkbox"/> No <input type="checkbox"/> Yes		
If the client requires crisis accomodation have they tried to access a women's refuge? <input type="checkbox"/> No <input type="checkbox"/> Yes		
Gender Identity		
Phone Numbers	Home	Mobile
If D&FV is and issues is it safe to call		<input type="checkbox"/> No <input type="checkbox"/> Yes
Code Word to use _____		
Current Address		Postcode
Date of Birth	____/____/____	Age
Cultural Identity		<input type="checkbox"/> Aboriginal <input type="checkbox"/> T.S.I.
Next of Kin	Name _____ Relationship _____	
	Phone Number _____	
	Address _____	
Disability	Do you require assistance with completing forms/ literacy etc.	Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="checkbox"/> No <input type="checkbox"/> Yes (specify nature of disability)		
What type of income do you have?		
<p style="font-size: small; color: red;">Our service is required to undertake data collection. This information is confidential and anonymous. If you choose not to consent to this you will still be provided with support from this service. If you have any questions or concerns about data collection, please talk to your caseworker.</p> <input type="checkbox"/> Yes <input type="checkbox"/> No Consent to record details on database (SHIP)		

Children's Details

Child 1	
Family Name	Other Names
Current Location/Address	<input type="checkbox"/> Same as mother or carer <input type="checkbox"/> Other, please specify
Date of Birth	/ / Age
Gender Identity	Cultural Identity
Concerns/issues for child	<input type="checkbox"/> Child Protection <input type="checkbox"/> Family Court Order <input type="checkbox"/> Other (please specify)
Which school does the child attend?	
Any medical, behavioural issues or special needs for this child?	

Child 2	
Family Name	Other Names
Current Location/Address	<input type="checkbox"/> Same as mother or carer <input type="checkbox"/> Other, please specify
Date of Birth	/ / Age
Gender Identity	Cultural Identity
Concerns/issues for child	<input type="checkbox"/> Child Protection <input type="checkbox"/> Family Court Order <input type="checkbox"/> Other (please specify)
Which school does the child attend?	
Any medical, behavioural issues or special needs for this child?	

Child 3	
Family Name	Other Names
Current Location/Address	<input type="checkbox"/> Same as mother or carer <input type="checkbox"/> Other, please specify
Date of Birth	/ / Age
Gender Identity	Cultural Identity
Concerns/issues for child	<input type="checkbox"/> Child Protection <input type="checkbox"/> Family Court Order <input type="checkbox"/> Other (please specify)
Which school does the child attend?	
Any medical, behavioural issues or special needs for this child?	

Child 4	
Family Name	Other Names
Current Location/Address	<input type="checkbox"/> Same as mother or carer <input type="checkbox"/> Other, please specify
Date of Birth	<div style="text-align: center;">/ /</div> Age
Gender Identity	Cultural Identity
Concerns/issues for child	<input type="checkbox"/> Child Protection <input type="checkbox"/> Family Court Order <input type="checkbox"/> Other (please specify)
Which school does the child attend?	
Any medical, behavioural issues or special needs for this child?	

Child 5	
Family Name	Other Names
Current Location/Address	<input type="checkbox"/> Same as victim <input type="checkbox"/> Other, please specify
Date of Birth	<div style="text-align: center;">/ /</div> Age
Gender Identity	Cultural Identity
Concerns/issues for child	<input type="checkbox"/> Child Protection <input type="checkbox"/> Family Court Order <input type="checkbox"/> Other (please specify)
Which school does the child attend?	
Any medical, behavioural issues or special needs for this child?	

CHILDREN/DEPENDENTS NOT CURRENTLY IN APPLICANT'S CARE							
Surname	Given Names	AGE	DOB	Gender Identity	Cultural ID	Family Orders	Are FaCs Involved
						No Yes	No Yes
						No Yes	No Yes
						No Yes	No Yes
Additional Information							

Details if Domestic or Family Violence if this is a presenting issue		
Perpetrator Details Given Name	Surname	
Does the perpetrator live in your household?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Current Location/Address		Postcode
Date of Birth	/ /	Age
Gender Identity		
Relationship Status	Length of R/ship: Are you separated? Yes No	
Details of most recent incident of Abuse (what and where)	<input type="checkbox"/> Emotional <input type="checkbox"/> Financial <input type="checkbox"/> Physical <input type="checkbox"/> Sexual <input type="checkbox"/> Social <input type="checkbox"/> Verbal	
Date of most recent incident of abuse?		
Has the matter been to court for a mention or hearing?	<input type="checkbox"/> No <input type="checkbox"/> Yes	
If yes, who are the police officers dealing with the matter?		
Is he in custody in relation to the D&FV matter?	<input type="checkbox"/> No <input type="checkbox"/> Yes	

Legal		
Do you have current legal issues?		Prompts: Family law, AVO, Criminal Charges, property etc.
Do you have a legal representation	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Contact details of legal representative		Optional
Additional Information		

Risk Assessment

I would like to have a chat with you to find out more about you, your family, and about (the perpetrator) so that I can understand your experiences and so that together we can work out any risks to you and your children. Once we have done that, we will then need to explore what happens next to keep you and your children as safe as possible from future harm. Does that make sense? Are you okay with starting?'

Note: these risk factors should be explored through the course of a conversation rather than in checklist fashion:

Risk Factors for Perpetrators	Yes	No	Comments	Prompts
Use of weapon in most recent event	<input type="checkbox"/>	<input type="checkbox"/>		
Access to Weapons	<input type="checkbox"/>	<input type="checkbox"/>		
Has he ever harmed or threatened to harm You	<input type="checkbox"/>	<input type="checkbox"/>		
Have the police been involved or called to an incident?	<input type="checkbox"/>	<input type="checkbox"/>		
Is there an AVO in place against perpetrator?	<input type="checkbox"/>	<input type="checkbox"/>		Notify that we need a copy of AVO
Are there criminal charges against perpetrator?	<input type="checkbox"/>	<input type="checkbox"/>		
Previous or current breach of AVO	<input type="checkbox"/>	<input type="checkbox"/>		
If perpetrator saw you in the community would they physically try to hurt you?	<input type="checkbox"/>	<input type="checkbox"/>		
Does anyone else want to harm?	<input type="checkbox"/>	<input type="checkbox"/>		
Drug and/or alcohol misuse/abuse	<input type="checkbox"/>	<input type="checkbox"/>		
Depression/mental health issues	<input type="checkbox"/>	<input type="checkbox"/>		

Risk Factors to Self	Yes	No	Comments	Prompts
Do you have any health condition for which you are, or should be, taking medication for	<input type="checkbox"/>	<input type="checkbox"/>		
Pregnancy/new birth	<input type="checkbox"/>	<input type="checkbox"/>		
Depression/anxiety/mental health issue <small>If MH diagnosis -worker to request letter from diagnosing doctor/service within first week of providing the service</small>	<input type="checkbox"/>	<input type="checkbox"/>	Diagnosis: Medication:	Consider asking questions about medications taken, health support services received, past admissions to psychiatric units, community treatment orders, children's care during periods of illness. Mental Health Team?
In the last 12 months have you self-harmed or felt suicidal?	<input type="checkbox"/>	<input type="checkbox"/>		Consider asking questions about the effect of those rough times; if this is happening now; how the person is dealing with those feelings. Look for talk of wanting to die; indications of no reason for living; reckless acts; giving away valued possessions; noticeable changes in daily activities like eating, sleeping or socialising; a plan or method.
Current use of illegal drugs? Do you drink Alcohol daily?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		Consider asking questions about current drugs or alcohol use; patterns of usage; drug and alcohol support received and needed; past experience with withdrawal symptoms, overdoses, seizures,

Binge drinking – do you have times of drinking a lot then nothing Use of legal/prescription drugs eg methadone, pain killers, relaxants etc.	<input type="checkbox"/>	<input type="checkbox"/>		blackouts, substance-induced aggression and self-harm
Do you have a support system	<input type="checkbox"/>	<input type="checkbox"/>		Ask about family, friends etc.

Relationship Factors	Yes	No	Comments	
Recent Separation	<input type="checkbox"/>	<input type="checkbox"/>		
Escalation – increase in severity and/or frequency of violence	<input type="checkbox"/>	<input type="checkbox"/>		
Financial difficulties	<input type="checkbox"/>	<input type="checkbox"/>		

Risk Factors to Others	Yes	No	Comments	Prompts
When you get angry do you yell and scream, break things, hit or hurt other people	<input type="checkbox"/>	<input type="checkbox"/>		Consider asking questions about any incidents of violence/assault; what makes the person angry; anger problems at other services; whether past incidents were in response to provocation, under the influence of alcohol or drugs, when ill or in crisis, immediately or a day after a stressful incident, impulsive or planned towards a person or object, towards men, women or children, towards a larger or smaller person
Have you had support from other services/people about anger & aggression issues?	<input type="checkbox"/>	<input type="checkbox"/>		
Do you have AVO or criminal charges against you?	<input type="checkbox"/>	<input type="checkbox"/>		Consider asking questions about incidents of violence/assault; what makes the person angry.
Have you had experience with the Police and legal systems?	<input type="checkbox"/>	<input type="checkbox"/>		Consider asking questions about Juvenile Justice or probation officers, bond or probation conditions, criminal convictions, support needed for outstanding legal matters.

Risk Factors from Others		Comments	Prompts
In what situations can your children get difficult to manage?			<p>Prompts: past involvement with Community Services, difficulties in controlling kids, challenging behaviours.</p> <p>Consider asking questions about how the kids have been coping with the situation; custody and access arrangements; details of challenging behaviours; support needed to manage the children.</p> <p>Consider questions regarding the family dynamics, sibling interaction etc.</p>

On a scale of 1-10 how safe do you feel? (if 1 means that you feel a little unsafe and 10 being that you feel extremely unsafe)

1 2 3 4 5 6 7 8 9 10

This scale could relate to D&FV, mental health, D&A or other issues identified in the intake.

What Services are you currently involved with?

Name of Service	Contact Person and Number	Type of involvement

Is Action Required? - Use Client Consent Form (attached)

Any Additional Information

Risk Level

Is risk present?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Is action required?	<input type="checkbox"/> No <input type="checkbox"/> Yes

CLIENT CONSENT FORM – TO OBTAIN AND RELEASE INFORMATION

(To be completed when required)

Client name: _____ DOB: _____

I, _____ give permission for the workers of the following services, agencies or people to release information relevant to myself or my children’s case plan to the workers **at Macarthur Gateway Resource Service**

- _____
- _____
- _____
- _____

This information may be shared verbally or in writing, whichever is most appropriate in the situation.

Signed

Date

Witnessed

Date

CLIENT CHECK LIST

Check list for Workers	
Client has received a copy of the service charter	<input type="checkbox"/>
Client has received a copy of how to make a complaint	<input type="checkbox"/>
Client has signed the release of information form	Y <input type="checkbox"/> N <input type="checkbox"/>
Client has received a copy of their case plan and any updates	<input type="checkbox"/>
Client has received a feedback form to rate their satisfaction with the service they received	<input type="checkbox"/>
Client has a copy of MGRC Confidentiality agreement	<input type="checkbox"/>
Client has a received a brochure about the service and the types of services they can receive	<input type="checkbox"/>
