| WDVCAS- Request for Service Form |
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| ****CLIENT INFORMATION****  |
| **Name:**  | **Referral Date:**  |
| **Aliases (if client is known by any other names):**  |
| **Date of birth:**  | **CRN:** | **Phone:** |
| **Current address:**  |
| **Town:**  | **State:**  | **Post Code:** |
| □ **Aboriginal**   | □ **Torres Strait Islander**  | □ **Non-ATSI** | □ **Not Stated**  |
| OTHER PARTY DETAILS (iF APPLICABLE) |
| **Name of other party involved in matter:**  | **DOB:**  |
| **Address:**  | **Phone:**  |
| **Town:**  | **Relationship to client:**  |
| REFErRING AGENCY/SERVICE |
| **Organization Name:**  | **Worker Name:**  |
| **Email:**  | **Phone:**  |
| reason for referral  |
| **LEGAL ASSISTANCE** **🞏 Care Proceedings □ Family Law****□ ADVO / AVO □ Legal Advice** **□ Other** | **COUNSELLING SUPPORT****🞏 Domestic Violence / Sexual Assault****□ Domestic Violence Program** **□ Other** | **CLIENT SUPPORT****🞏 Court Support****🞏 Victims Support Scheme*** **Family care program**
* **Homelessness specialist**
* **Counselling**
* **Family Mental Health Service (youth)**

**🞏 Safety Planning** |
| **Has client had any previous legal advice? □ No □ Yes** |
| **Does client have a court date/existing order? □ No □ Yes Details-**  |
| **Has a DVSAT been completed? □ No □ Yes\_\_\_\_\_\_\_\_if yes, Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Attached □ No □ Yes**  |
| ***Outline of reason for referral:*** |
|  |
|  |
|  |
|  |
| ***FOR INTERNAL OFFICE USE ONLY*** |
| **Conflict Checked: 🞏 Yes**  | **By Whom:**  | **Date:** |
| **Name of worker Completing Form:** | **Date:** |
| **Action: 🞏 No conflict, able to assist, internal referral to:**  |
| **Action: 🞏 Conflict / unable to assist, referred to:**  |
| client INTAKE FORM  |
| DEPENDANT CHILDREN |
| **Child 1.**  | **First Name:**  | **DOB:**  | **AGE:** | **SEX:**  |
| **Relationship to client:**  | **Lives with:**  |
| **Child 2.**  | **First Name:**  | **DOB:**  | **AGE:** | **SEX:**  |
| **Relationship to client:**  | **Lives with:**  |
| **Child 3. Surname:**  | **First Name:**  | **DOB:**  | **AGE:** | **SEX :**  |
| **Relationship to client:**  | **Lives with: Mother**  |
| **Child 4. Surname:**  | **First Name:**  | **DOB:**  | **AGE:** | **SEX:** |
| **Relationship to client:** | **Lives with:** |
| **Child 5. Surname:**  | **First Name:**  | **DOB:**  | **AGE:** | **SEX:** |
| **Relationship to client:** | **Lives with:** |
| **Child 6. Surname:**  | **First Name:**  | **DOB:**  | **AGE:** | **SEX:** |
| **Relationship to client:** | **Lives with:** |
| ***Additional Notes-***  |

**Office: 4476 5416 Email service requests to- fsc@wdvcas.org**