Family Services Australia

Drug, Alcohol Program & Parenting Service (DAPPS) Form

(Available only in the Shoalhaven LGA)

REFERRING AGENCY			
Referral Source:			
Contact Name:		Phone:	
Email:		Mobile	
Has the Client consented to this Referral?	☐ Yes	☐No	
Consent for personal information collection for DSS Data Exchange	☐ With name	☐Without name	☐No

PRIMARY CLIENT INFORMATION	
First Name:	Last Name:
Birthdate	Gender: ☐ Male ☐Female
Phone:	Mobile:
Street:	
Suburb:	Post Code:
Email:	

PARTNER INFORMATION	
First Name:	Last Name:
Birthdate:	Gender: ☐ Male ☐ Female
Phone:	Mobile:
Street:	
Suburb:	Post Code:
Has Client's Partner consented to this Referral?	Yes ☐ No ☐

SECONDARY CONTACT	
Name:	Relationship:
Phone:	Mobile:

CHILDREN

In order to be eligible for DAPPS, the client must have at least one child under 9 years of age.

First AND Last Name:	Gender:	Birthdate:	Age:	Education Provider:

Unborn – Gestation/Trimester Period	
Last substance use prior to conception	
Last substance use since conception	
Last substance use since birth	

OTHER INFORMATION

Country of Birth:	Aboriginal or Torres Strait Island?	☐ Yes	☐ No
Main Language Spoken:	Is an Interpreter Required?	☐ Yes	☐ No

Household Tenure (Rental/ Mortgage/Refuge):

Other Support Available to Family:

Other Services Currently Involved/Length of Time Involved:

Tasks Completed/Working Towards

Current Case Plan: ☐ Yes ☐ No ☐ DCJ ☐ BF ☐ SAHSS ☐ Other
Start Date:
Approx Closure Date (If applicable):

Are any Orders in Place (AVO, Legal, Family Law?):

WH&S Concerns (Please provide details if the referrer is aware of any WH&S risks):

What are the family's current protective factors and/ or strengths?

Is anyone in your family currently engaged with a Psychologist, Psychiatrist or Counsellor? If yes, please list who:

Do you have a NSW State Debt? ☐ Yes ☐ No

FAMILY ISSUES	YES	COMMENTS - (Use Additional Notes Section If Needed)
Domestic Violence:	☐	
Mental Health - Adult:	☐	
Mental Health - Child:	☐	
Physical Health - Adult:	☐	

Physical Health - Child:	☐	
Developmental Delays - Adult:	☐	
Developmental Delays - Child:	☐	
Child Abuse/ Neglect:	☐	Known Reports of Abuse: ☐Yes ☐No Type of Abuse:
Behaviour Issues:	☐	
Financial Difficulty:	☐	
School/ Education:	☐	
Housing/ Homelessness:	☐	
Household Management:	☐	
Isolation:	☐	
Loss/ Grief:	☐	
Parenting Related Concerns:	☐	
Substance Abuse:	☐	1. Type of Abuse: 2. Choice of Substance/s: 3. ☐ Addiction ☐ Regular ☐ Casual 4. Length of Use a. ☐ Long Term b. ☐ Short Term
SERVICES REQUESTED	**YES**	**COMMENTS - (Use Additional Notes Section If Needed)**
Advice & Referral:	☐	
Case Management:	☐	
Parenting Skills Development:	☐	
Practical Skills Development:	☐	
Community Engagement:	☐	
Other:	☐	

ADDITIONAL NOTES SECTION

FOR FSA USE ONLY		
Date Received:		
Accepted: ☐	Declined: ☐	Pending: ☐
Client ID:	Open Access Primary Client Number:	
FS Unique ID:	Open Access Partner Client Number:	
Prior FS Unique ID:		
Funding Source:		

Privacy Statement:
We value your personal and private information and strive to protect it. In the collection, handling and storage of personal information, Family Services Australia complies with the legislative requirements of the Commonwealth and NSW Governments related to the protection of privacy and personal information.

Please save a copy of this Referral to your computer and then complete.
Email your completed Referral PDF to Family Services Australia at referrals@familyservices.org.au
Phone 1800 372 000 Option 5 (1800 FSA 000) for any enquiries.