Macarthur Family and Youth Services

Intake Form

Please note that boxes marked with a * are mandatory
Please note that we only support families who reside in Campbelltown and Camden.

Referral Date *		Completed By*:	

Referrer Information

Person making the referral *	
Agency/Relationship to family *	
Address	
Email *	
Phone Number *	
Confirmation the referrer has advised the family/young person the referral is being made: *	☐Yes ☐No (If no ask the referrer to gain the family/young person's approval before proceeding)

Client Information

Previous client of MFYS: Yes / No / Unknown			MFYS Case ID:		
Primary Contact: Parent/Carer/Young Person (please indicate)			LGA of client*: ☐Campbelltown ☐Camden		
Name*					
DOB*					
M/F*		Age *		Parent under 21yr ☐Yes ☐No	
Mobile No.*		Is it safe to call or text you on this number ☐Yes ☐No			
Address*					
Suburb *					
Other Carer: * Should this person be contacted regarding the referral Yes/No					
Name*					
DOB*					
M/F*		Age *			
Mobile No.*					
Address*					
Suburb*					

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Children/Young Person's Details:

Name *	Age *	D.O.B *	M/F*	Relationship *	Disability *

Child Protection Information

Past or current Child Protection concerns with Department of Community Justice (DCJ)? * ☐Yes ☐No (Please highlight) If yes, state concerns: * If yes, state concerns: *	
Is there a current open file with DCJ? ☐Yes ☐No (Please highlight)	
DCJ Community Services Centre (CSC) Unit	
Case Worker Allocated	
Contact phone number	

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Cultural Background

Does anyone in the Family identify as Aboriginal*	☐Yes ☐No (If yes, please list)
Does anyone in the Family identify as Torres Strait Islander*	☐Yes ☐No (If yes, please list)
Does the client identify as being Culturally or Linguistically Diverse *	☐Yes ☐No (Please highlight)
Country of Birth *	
Language spoken at home*	
Is an Interpreter required? * If Yes, please specify language	☐Yes ☐No (Please highlight) Language:

Financial Counselling Support

Would you like a Financial Counsellor to call to make an appointment? (free service) *	☐Yes ☐No (Please highlight)
Would you like a Problem Gambling Counsellor to call to make an appointment? (free service) *	☐Yes ☐No (Please highlight)

Safety Issues

Worker Safety Issues:*

☐ Dogs /Animals ☐Access issues ☐Clear house number ☐Nearest cross street

Does anyone smoke/vape in the house? ☐Yes ☐No ☐Other

Is there someone other than those listed on the referral regularly at the home? ☐Yes ☐No

If yes please give details

Is there anything else we should know? ☐ Yes ☐No ☐don't know

Details:

☐ Mental Health ☐Substance Abuse ☐Domestic Violence ☐ Homelessness

☐ Schooling ☐ Immigration / Visa

Please provide as much information as you can as this will assist MYFS during intake and allocation.

Details of referral: (e.g What are you seeking support for? What supports do you think might help your family's current situation?)

Background: (e.g Do you have any current supports or services in place?)

Any other information that you feel we need to know that is not listed above:

On completion, please email this form to admin@mfys.org.au or alternatively please call us 46 20 4667 and we can assist you over the phone