

OFFICE USE ONLY

Date Case Allocated: ___/___/___

Parent/Carer IA: ___/___/___ Counsellor: _____

Child IA: ___/___/___ Counsellor : _____

Ref: _____

Transforming Trauma



Galileo House Referral

E-mail to reception@sass.org.au or Fax to 6231 1455

Name of child: _____ Date of Referral: ___/___/___

Date of Birth: ___/___/_____

Parent/Carer's Name: _____

Address: _____

Safe Contact Phone No: _____ Mobile: _____

Siblings: _____

Current Living/Family situation: _____

Parent/Carer Notified: Yes No

If not notified, give reasons why: _____

Name of person referring: _____

Phone/email: _____

Reasons for Referral: _____

Date reported to CPAARS or Police: ___/___/_____

If not reported, give reasons why: _____

Other Agencies/Services Involved: _____