Strengthening Parent Support Program
Form C: Referral IN

Referring to Strengthening Parent Support Program		**Referral from**	
Name		Name	
Position		Position	
Service provider		Service provider	
Email		Email	
Phone		Phone	

Family details

Parent(s)/carer(s)	
Family name	
Given name(s)	
Phone	
Email	
Home address	

Child(ren)			
Child(ren)'s name	Date of birth	Type of disability or developmental delay	
		☐ Acquired Brain Injury ☐ Autism Spectrum Disorders ☐ Cerebral Palsy ☐ Hearing/Vision Impairment ☐ Developmental Delay ☐ Down Syndrome	☐ Intellectual Disability ☐ Muscular Dystrophy ☐ Spinal Cord Injury ☐ Specific Learning Disability ☐ Other: _______________ ☐ None
		☐ Acquired Brain Injury ☐ Autism Spectrum Disorders ☐ Cerebral Palsy ☐ Hearing/Vision Impairment ☐ Developmental Delay ☐ Down Syndrome	☐ Intellectual Disability ☐ Muscular Dystrophy ☐ Spinal Cord Injury ☐ Specific Learning Disability ☐ Other: _______________ ☐ None
		☐ Acquired Brain Injury ☐ Autism Spectrum Disorders ☐ Cerebral Palsy ☐ Hearing/Vision Impairment ☐ Developmental Delay ☐ Down Syndrome	☐ Intellectual Disability ☐ Muscular Dystrophy ☐ Spinal Cord Injury ☐ Specific Learning Disability ☐ Other: _______________ ☐ None

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Issues that parent felt the Strengthening Parent Support Program may assist with
_____
_____
_____
_____
_____
Reason for referral as identified by referrer
_____
_____
_____
_____
_____
Other services the family is currently accessing
_____
_____
_____
_____
_____
Notes
_____
_____
_____
_____
_____

PRIVACY STATEMENT: The Strengthening Parent Support Program (SPSP) is funded by the Department of Education and Training (the Department). The service agreement between the Department and the service provider delivering the SPSP requires the service provider to collect personal and health information about you and your child/ren using this form in accordance with the *Privacy and Data Protection Act 2014 (Vic)*.

Personal and health information is collected to provide the most appropriate services for you as part of the SPSP. While an individual may choose not to provide personal information to us, failure to do so may impact the provision of services as part of the SPSP.

All personal information provided is kept secure and confidential. It is only disclosed to the SPSP Coordinator listed above for the purpose of the referral into the SPSP. An individual may request access to their personal information by contacting the service provider using the details below.

I have discussed the proposed referral with the parent. I am satisfied that the parent understands the proposed referral and I have their informed consent for the release of information.

Referrer signature: _____ Date: _____

I consent for the referrer to provide the information on this form to the Strengthening Parent Support Program Coordinator and understand that the Coordinator may discuss the information with the referrer to inform my involvement in the program.

Parent signature: _____ Date: _____