Parent Peer Support Program
Referral Form

To be eligible for MIFWA's Parent Peer Support Program, the parent must be experiencing or impacted by mental illness, has a child under 18 years old living at home, and is living in the North Metro Mental Health Service Area.

About the parent being referred

First name | Surname

Gender

Date of birth

Home address

Phone

Email

Relationship status | Current living situation

Country of birth | Ethnicity

Main language spoken at home | Is an interpreter required? Yes ○ No ○

Currently receiving services through the NDIS? Yes ○ No ○

Currently applying for NDIS? Yes ○ No ○

Referrer's details

How did you hear about us?

Name | Relationship to parent

Organisation

Address

Current role

Phone | Email

Current support services received

Service | Contact person

Current referrals made

Name of organisation | Service assists the parent with

Is there past or current involvement with the Department for Child Protection and Family Support?

If yes, please provide more information.

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Does the parent have any allergies or other medical conditions? ○ Yes ○ No

If yes, please provide details about the current condition and treatment.

The other parent/partner

Is there another parent/partner living in the home? ○ Yes ○ No

If yes, please provide details

First Name | Surname

Gender | Date of birth

Home address | Suburb | Postcode

Phone

Email

Relationship to the participant | Current living situation

Country of birth | Ethnicity

Main language spoken at home | Is an interpreter required? ○ Yes ○ No

About the children living at home

First name	Surname	Date of birth	Gender
1.			
2.			
3.			
4.			

Current living situation

Other people living in the home:

First name | Surname

Current living situation | Relationship to the parent or family

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Signature, consent, and declaration

- By completing this document, I confirm that the parent agrees to this referral and gives their consent for it to be submitted to MIFWA and MIFWA may contact any service providers named for further information. I understand that I can withdraw from this referral or from the referred service at any time. All information will be treated confidentiality and will only be used for the purposes stated in this form.

Parent's consent

Full name | Signature

Date

Referrer's signature

Full name | Signature

Date