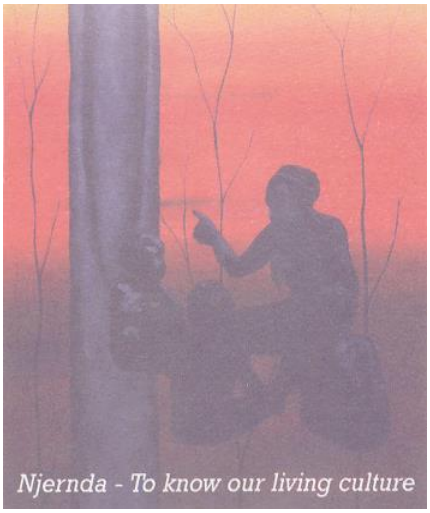

NJERNDA ABORIGINAL CORPORATION
CRADLE TO KINDER
External Referral Form

PRIOR TO REFERRAL:

Does this client meet the Loddon Cradle to Kinder Criteria below:

Is the client based in the Loddon Catchment Area?	*Yes/No*
Is the client Aboriginal or pregnant with an Aboriginal Child?	*Yes/No*
Is the client under 25 years of age?	*Yes/No*
Has the client been involved with Child Protection or at Risk of Child Protection Involvement?	*Yes/No*
Has the client been in out of home care themselves?	*Yes/No*
Does the client have an intellectual learning disability?	*Yes/No*

Other Reasons for Referral to Njernda's Aboriginal Cradle to Kinder Program

Please call Leona or Gabby at Berrimba Childcare Centre 03 5481 1900 if you have any questions related to completing this form.

PERSONAL PARTICULARS:

PARENT'S NAME (1):_____DATE OF BIRTH:_____

PARENT'S ADDRESS:_____

_____

PHONE/CONTACT DETAILS:_____

CULTURAL IDENTITY:

ABORIGINAL TORRES STRAIT ISLANDER OTHER

PARENT'S NAME (2):_____DATE OF BIRTH:_____

PARENT'S ADDRESS:_____

_____

PHONE/CONTACT DETAILS:_____

CULTURAL IDENTITY:

ABORIGINAL TORRES STRAIT ISLANDER OTHER

SUPPORT PERSON/EMERGENCY CONTACT: _____

R/SHIP:_____

ADDRESS: _____

PHONE/CONTACT DETAILS:_____

How many weeks pregnant? _____ OR Age of Newborn: _____

(Referrals must be made between 26 weeks pregnant or before the newborn is 6 wks old)

OTHER CHILDREN:

1._____DOB:_____Age:_____

2._____DOB:_____Age:_____

3._____DOB:_____Age:_____

4._____DOB:_____Age:_____

Are the other children staying at home or somewhere else? If so where are they staying and who with?

_____

_____

_____

Does the client already access any services at Njernda Aboriginal Corporation? Yes/No

If Yes what program? _____

_____

REFERRAL PROCESS:

REFERRED BY: _____

CONTACT NUMBER: _____

DATE: _____

Client Authority:

I _____ hereby give my consent to be referred to the Cradle to Kinder Program and for my information to be shared with the Early Years Manager and Cradle to Kinder Coordinator.

Signed: _____ Date: _____

Please forward this form to leonac@njernda.com.au or gabbyj@njernda.com.au and await confirmation of receipt.

The client will be contacted by Gabby Johnson Cradle to Kinder Coordinator

(Ph: 0407 997 465) or Leona Cooper Early Years Manager (Ph: 0400 354 480) with in two working days from the date of referral.

OFFICE USE ONLY

Date Received by C2K Coordinator: _____

Date Contact made: _____

REFERRAL PROCESS:

Referral emailed to C2K Coordinator/Early Years Manager

↓

C2K Coordinator/Early Years Manager will acknowledge receipt of referral

↓

Client to be contacted within 2 working days to arrange time to meet

↓

Appointment made and Intake form completed

↓

Care Plan created