CS – (Individual) Referral to Preschool Field Officer Program

This support request will focus specifically on assisting with inclusion of the child.

CHILD INFORMATION

	First	Surname	
Child's Name			
Date of birth		Male ☐ Female ☐ Non-Identified ☐	
Country of birth		Language spoken	
Cultural or Religious requirements			
Interpreter required	Yes ☐ No ☐	Language	

Aboriginal and Torres Strait Islander Status

Neither Aboriginal nor Torres Strait Islander ☐ Aboriginal but not Torres Strait Islander ☐

Torres Strait Islander but not Aboriginal ☐ Both Aboriginal and Torres Strait Islander ☐

ELIGIBILTY

3 -year-old kindergarten ☐ 4-year-old kindergarten ☐

Early Start Kinder (ESK) ☐ 2nd year of 4-year-old kindergarten ☐

KINDERGARTEN

Name of Kindergarten	
Name of Educator	
Email	
Telephone	
Address	

Session times: **Please fill in the days and times child attends kindergarten.**

	Monday	Tuesday	Wednesday	Thursday	Friday
Session Times					
Planning Time					

FAMILY

	First	Surname	
1.Parent/Guardian **(Primary contact)**			
Relationship to Child			
Address			
Phone		Mobile	
Email			
Language spoken at home		Interpreter Required Yes ☐ No ☐	
Literacy level	Assistance required Yes ☐ No ☐		

2. Parent/Guardian			
Relationship to Child			
Address			
Phone		Mobile	
Email			
Language spoken at home		Interpreter Required Yes ☐ No ☐	
Literacy level	Assistance required Yes ☐ No ☐		

Please add as much detail as possible, attach separate sheets if needed.

SERVICES/SUPPORTS

What are the services / supports your child has received or is receiving?

Example; GP, National Disability Insurance Scheme (NDIS), Dietician, Therapist, Hearing, Vision, Psychologist and Paediatrician

Name	**Name of Service**	**Contact Number**	**Date last seen or due to be seen**

Please add as much detail as possible, attach separate sheets if needed.

FOR PARENT/GUARDIAN TO COMPLETE

MATERNAL CHILD HEALTH NURSE

Attended MCHN visits for 2-year-old check-up ☐ 3.5-year-old check up ☐

Feedback from visit, any concerns or referrals made?

When you think about your child, what are their strengths and interests?

When you think about your child, what concerns do you have?

Parent/Guardian level of concern: (Please Tick)

Slight ☐ Moderate ☐ High ☐

EDUCATOR TO COMPLETE

When you think about the child you are referring, what are their strengths/interests?

When you think about the child you are referring, what concerns do you have?

Educator's level of concern (please tick)

Slight ☐ Moderate ☐ High ☐

What strategies/supports have you and the family tried already to address the concerns?

What were the outcomes? Were they effective?

As an educator, what support do you require from the Preschool Field Officer to build your capacity?

What outcome would you like to achieve from working with the Preschool Field Officer?

AGREEMENT AND CONSENT

So that Pinarc can provide the best service possible, we need your permission to collect and share information that will help us and other services provide support to you.

Childs Name:

Date of Birth:

Address:

I give permission for Pinarc to:

☐ **collect and share** information with relevant people who may be involved with my support including but not limited to other health professionals, partner, family, other service providers and government agencies.

Please list if there is anyone you request **not** to share information with

☐ I **do not** give permission for Pinarc to **collect and share** information about me. Note: this may limit the service that Pinarc is able to provide.

☐ Use digital technology to best support the kindergarten when including my child (eg. Photos, videos, digital conferencing)

Family

☐ We have received a copy of the PSFO Fact Sheet

www.education.vic.gov.au/childhood/professionals/needs/Pages/psfo.aspx

☐ We are aware of information within this referral

Your details may be collected and disclosed to the Department of Education and Training (the department) for specific purposes, including for the department's auditing, monitoring and reporting.

Referrals can only be accepted when signed by hand

Parent / Guardian Signature: Date:

Parent/Guardian Name:

Referrer

Referrer Signature: Date:

Referrer Name:

RETURN THIS FORM TO PINARC DISABILITY SUPPORT- PSFO PROGRAM

Email: psfo@pinarc.org.au

Post: PSFO Program
Pinarc Disability Support
Wadawurrung Country
P.O Box 1841 Bakery
Hill, VIC 3354