

# CS- Referral to Preschool Field Officer Program



## CHILD INFORMATION

	First	Surname	
Child's Name			
Date of birth		Male <input type="checkbox"/>	Female <input type="checkbox"/> Non-Identified <input type="checkbox"/>
Country of birth		Language spoken	
Cultural or Religious requirements			
Interpreter required	Yes <input type="checkbox"/> No <input type="checkbox"/>	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

## ELIGIBILITY

3-year-old kindergarten 
 4-year-old kindergarten   
 Early Start Kinder (ESK) 
 2<sup>nd</sup> year of 4-year-old kindergarten

## KINDERGARTEN

Name of Kindergarten	
Name of Educator	
Telephone	
Address	
Email	

**NB:** When submitting your PSFO referral the service must ensure the email is sent from the kindergarten service's @kindergarten.vic.gov.au email, the early childhood teacher's or early years manager's **service** email. **No private email addresses will be accepted.** (e.g. @hotmail.com, @gmail.com)

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

	Monday	Tuesday	Wednesday	Thursday	Friday
Session Times					
Planning Time					

**FAMILY**

1. Parent/Guardian  
(Primary contact)  
Relationship to Child

First	Surname	
Address		
Phone	Mobile	
Email		
Language spoken at home	Interpreter Required	Yes <input type="checkbox"/> No <input type="checkbox"/>
Literacy level	Assistance required Yes <input type="checkbox"/> No <input type="checkbox"/>	

2. Parent/Guardian  
Relationship to Child

Address

Phone

Email

Language spoken at home

Literacy level

Address		
Phone	Mobile	
Email		
Language spoken at home	Interpreter Required	Yes <input type="checkbox"/> No <input type="checkbox"/>
Literacy level	Assistance required Yes <input type="checkbox"/> No <input type="checkbox"/>	



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*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

If so, as a part of this visit did your MCH nurse complete the Brigance developmental screen?

Yes  No  Unsure  Date of screen:

**NB:** If yes. Please attach a copy if available.

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.

Child's 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**

I/ We have received a copy of the PSFO Fact Sheet

<https://www.education.vic.gov.au/childhood/professionals/needs/Pages/psfo.aspx>

I/ We are aware of information within this referral

I/ We have been provided with a copy of the completed referral form

***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.***

Parent / Guardian Signature:

Date:

Parent/Guardian Name:

### **Referrer**

Referrer Signature:

Date:

Referrer Name:

### **PLEASE RETURN THIS FORM TO PINARC DISABILITY SUPPORT- PSFO PROGRAM**

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

**Email:** [psfo@pinarc.org.au](mailto:psfo@pinarc.org.au)

