



**Referral Form
Parent And Infant Relationship Support Group (PAIRS)
October 2008 – February 2009**

For more information and/or for an opportunity to meet and discuss whether the group might help parent/baby, please complete this form and forward to:

Lynne Allison
Box Hill CAMHS
Level 3/43 Carrington Rd
Box Hill, 3128
Phone: 9843 1200
Fax: 9843 1299

Anne Holland
FaPMI Coordinator, Adult Mental Health Service
1/43 Carrington Rd
Box Hill, 3128
Tel: 9843 5851
Fax: 9843 5808
Mob: 0408 291 580

Date: --- / --- / -----

Mother's Name: -----

Baby's Name: ----- **Baby's Surname(if different to mother):** -----

Baby's Date of Birth: --- / --- / ----- (between 4 and 12 months at start of group)

Address: ----- **Telephone:** -----

----- **Mobile:** -----

----- **P/Code:** -----

Partner/Significant other: -----

Other Children (Name, Age and Gender): -----

Are baby/children in parents care: Y/N. If no, please give details _____

Emergency Contact Details: _____

Has this referral been discussed with the parent?: **Yes** **No** (please circle)

Referrer Name: ----- (please print clearly)

Centre/Address: -----

Telephone: -----

Reason for Referral: -----

Current Supports for parent and family

Name of Worker----- **Agency** -----

Contact Details -----

Signature of Referrer: -----

Date: -----