ANGLICARESA

Government of South Australia

Acorn Parent-Infant Attachment Group - Referral Form

The Acorn groups support parents of infants aged 0 to 3 years who have diagnosed mental health difficulties and who have some difficulties in their relationship with their child (ren).

Acorn is structured to strengthen the parent-infant relationship through experiences of shared play, music and movement and some dedicated parent only time for reflection.

Please direct completed referral forms and any enquiries about the group to:

Janelle Hutt – Coordinator Acorn Parent-Infant Attachment Groups

P 8131 3485 |F 8131 3477 |E jhutt@anglicaresa.com.au

Client Information

Name:_____

DOB:_____

Address:_____

Phone:_____

Name and DOB of child who will be attending the group:_____

Names and DOBs of any other children in the family: _____

_____

_____

Is this person Aboriginal or Torres Strait Islander? Yes ☐ No ☐

Referrer Details

Name of referrer:_____

Role with family:_____

Agency / Service:_____

Phone:_____

Email:_____

Summary of mental health concern (e.g. depression & anxiety symptoms, duration of symptoms, recent stressors, past mental health problems, relationship issues):

_____
_____
_____
_____
_____

Aim of Referral (please detail your intended outcomes for this referral):

_____
_____
_____
_____

Please detail the client's strengths / what is working well in the client's life:

_____
_____
_____
_____

Client's current mental health management plan:

GP involvement (including contact details)

_____
_____
_____
_____

Therapist involvement (including contact details)

_____
_____
_____
_____

Other services/supports (including contact details)

_____
_____
_____
_____

Medication

_____
_____
_____
_____

Are there any other issues that we should know about when working with this client and their family? (e.g. child protection involvement, family court involvement, safety concerns)

_____
_____
_____
_____

Which Acorn Group would be most suitable for the referred person?

- ☐ Norwood
- ☐ Plympton South (Forbes Children's Centre)
- ☐ Woodcroft Heights
- ☐ Elizabeth
- ☐ Smithfield Plains *(group for Aboriginal families)*

Has the referred person given permission for this referral to be made? Yes ☐ No ☐

Has the referred person had a medical review in the last month? Yes ☐ No ☐

Does the referred person or child have any food allergies? Yes ☐ No ☐

Details_____

Is the referred person given consent for their GP to be contacted if necessary? Yes ☐ No ☐

May we leave a message on the referred person's voice mail? Yes ☐ No ☐

Date of Referral ___/___/_____

Please attach any additional information you think may be useful to this referral