Acorn Parent-Infant Attachment Group – Request for Service

The Acorn group supports mothers whose diagnosed mental health difficulties impact on parent-infant attachment. It is a structured, 15 week program that utilises shared experiences of play, music and movement, and dedicated parent-only time for journaling and peer support. It aims to enhance parent-child interaction and strengthen mothers' relationships with their child/ren aged birth to 30 months at the commencement of group.

Referrals are accepted from Health Professionals. Acorn is designed to complement, rather than replace, existing professional mental health support services.

Please direct completed Requests for Service **(incomplete forms will not be accepted)** and any enquiries about Acorn to *Coordinator, Acorn Parent-Infant Attachment Groups:*

P 8131 3485 | E acorn@anglicaresa.com.au

The referrer will be contacted regarding the outcome of the Request for Service within the first four weeks of group.

Client Information

Name: _____

DOB: _____ Phone: _____

Address: _____

Suburb: _____ Postcode _____

EMAIL (required): _____

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

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

_____

_____

Is the Parent Aboriginal or Torres Strait Islander? Yes ☐ No ☐

Is the Child/Children Aboriginal or Torres Strait Islander? Yes ☐ No ☐

Are there any cultural or language factors that may be relevant for this mother and child(ren) (eg. Cultural identity / background / parenting practices / family roles etc.)?

Referrer Details **Date of Referral** ___/___/_____

Name of referrer: _____

Phone: _____

EMAIL (required): _____

Organisation: _____

Role with family: _____

Will you continue your role with this client during the course of this Acorn program?

Yes ☐ No ☐

Client's current mental health management plan

General Practitioner

Name: _____

Practice name and address: _____

Phone (required): :

_____

EMAIL (if possible)_____

Please list current
medication/s_____

_____

_____

_____

Has consent been provided to contact the GP about this RFS and on-going liaison as necessary? Yes ☐ No ☐

If no, please nominate a health professional responsible for mental health management.

_____

_____

_____

_____

Other therapeutic / support services (including contact details – name / role & phone &/or email)

_____

_____

_____

_____

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

Are there any physical health issues (disabilities or health conditions) that may impact how the client and / or child/ren participate?

Are there any factors that may impact the client's ability to attend the full 15 week program (e.g. return to work, stage of pregnancy)?

Please detail your intended group outcomes for this client, should an Acorn place be offered:

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

Are there any current court sanctioned, residency, parental responsibility or contact orders in place at this time (e.g. child protection, family court, family violence / safety concerns)?

When visiting the client's home are there any safety issues which the Parent Infant Attachment Practitioner needs to be aware of?

❑ **No**

❑ **Yes** - if yes, please explain:

_____
_____
_____
_____

Please number 3 group locations in order of client preference:

_____	Darlington	Monday am
_____	Windsor Gardens	Monday am
_____	Mt Barker	Tuesday am
_____	Aldinga Beach	Tuesday am
_____	Salisbury North	Wednesday am
_____	Norwood	Thursday am
_____	Parafield Gardens	Friday am
_____	Pennington	Friday am

Has the client given permission for this request for service to be made?

Yes □ No □

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