



Alternative Care Initial Inquiry

Date (of inquiry): ____ / ____ / 20____

Family surname/s: _____

Address: _____

_____ Post code: _____

Home telephone: _____ Work telephone: _____

Mobile telephone: _____ Other Telephone: _____

FAMILY DETAILS:	Given names:	Age:	Occupation:
Adult:	_____	_____	_____
Adult:	_____	_____	_____
Child:	_____	_____	_____
Child:	_____	_____	_____
Other household residents: _____			

REASON FOR CONTACT:

Information on Emergency Care:	<input type="checkbox"/>	Information on Long Term Care:	<input type="checkbox"/>
Information on Temporary Care:	<input type="checkbox"/>	Information on Respite Care:	<input type="checkbox"/>

REFERRAL SOURCE:

Family/Friend	<input type="checkbox"/>	Parish/School Bulletin	<input type="checkbox"/>	Newspaper Ad/Article	<input type="checkbox"/>
Radio	<input type="checkbox"/>	Television	<input type="checkbox"/>	Other (specify) _____	

Involvement (past, present or planned), with any other care services e.g.: Family Day Care, Disability Services: _____

Reasons for wanting to Foster: _____

Age of Children Willing to Foster: _____

FACILITIES:	Bedroom space:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Car passenger space:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Swimming pool:	<input type="checkbox"/> Yes	<input type="checkbox"/> No

OFFICE USE ONLY

ACTION TAKEN:	Date: ____ / ____ / _____	
	Letter and brochure sent	<input type="checkbox"/>
	Date of next information session	<input type="checkbox"/>
	Follow up interview or home visit scheduled	<input type="checkbox"/>
	Referred to other services	<input type="checkbox"/>

INQUIRER WISHES TO:	Think it over and re-contact	<input type="checkbox"/>
	Attend information session or home visit	<input type="checkbox"/>
	Be put on mailing list	<input type="checkbox"/>
	Other: _____	

RESULT: Application to foster received on: ____ / ____ / _____

Carer assessment to proceed: Yes No