Bathurst Family Support Service

205 Rankin St/PO Box 1523 Bathurst NSW 2795

Ph: 6331 7022

Parent-Child Interaction Therapy (PCIT)

REFERRAL FORM

PCIT is an evidence based parenting program that targets children aged 2-7 years who are displaying behavioural difficulties such as aggression, tantrums and defiance. It can also be useful for children who are withdrawn, shy or have separation anxiety.
PCIT aims to teach parents specific skills to enhance the parent-child relationship and to reduce negative behaviours.
If this referral does not meet these criteria please contact BFSS to discuss the referral or other appropriate interventions.

REFERRER DETAILS	
Date	
Name of referrer	
Organisation	
Phone contact	
Email	

CHILDREN IN THE FAMILY			
Child's first name	**Child's surname**	**Date of birth**	**Does the child live at home?**
Which child would participate in PCIT with the parent?			
Does this child have a disability or additional needs? Please provide details			

PARENT/CARER DETAILS	
Parent/carer 1 name	
Relationship to child	
Address	
Phone contact	
Cultural identity	
Parent/carer disability?	
Parent/carer 2 name	
Relationship to child	
Address	
Phone contact	
Cultural identity	
Parent/carer disability?	
Name of parent/carer being referred to PCIT	

BACKGROUND INFORMATION/PRESENTING ISSUES

CASE MANAGEMENT DETAILS	
Will you or your agency continue to work with this family or members of this family? If yes, please provide details	
Who is the appropriate contact person in your agency for follow up and contact regarding this referral? Please provide contact details if different from referrer	
Are you aware of any other services that this family is currently accessing? Please list	

CLIENT CONSENT

I _____ consent to this referral being made to Bathurst Family Support Service for Parent-Child Interaction Therapy. I have read the information provided in this referral, and I consent to the exchange of relevant information about myself and my family between the organisation making this referral and BFSS.

Signature _____ date _____

If you are unable to obtain written consent from the person being referred, have you obtained verbal consent?

☐ yes

☐ no

Please note that BFSS cannot accept the referral without consent from the person being referred

REFERRER AUTHORISATION

Signature of referrer _____ date _____

Please forward this referral to Bathurst Family Support Service by one of the following options:

- Email: admin@bfss.org.au
- Post: PO Box 1523 Bathurst NSW 2795

Thank you for forwarding the referral, we will advise you of the outcome of this referral.