I&R and Intake Assessment Form

Name of Safe Place Caseworker:**		☐ **I&R** ☐ **INTAKE**
Date of Assessment / Referral:**		

REFERRAL INFORMATION (as applicable) ****

Referring Organisation OR Individual (as applicable)			
Referral Organisation OR **Individual's Name:**			
For referral organisation - **Name of Caseworker in-charge:**			
Caseworker OR **Referral Individual's Email:**		**Caseworker** OR **Referral Individual's Contact No.:**	
Relationship to Client:		**Social Report Attached:**	☐ **Yes** ☐ **No**

BACKGROUND OF CLIENT

Name of Client:**			
Date of Birth:**		**Pregnancy Stage/Est. Deliv. Date:****	
Address (as per NRIC):	Postal code:		
Address (place of stay):	Postal code:		
Contact No(s):			
NRIC/Passport No:		**Nationality:**	
Marital Status:		**No. of children:**	
Hospital/Clinic:		**Name of Doctor:**	
Name of Client's Father or Mother:		**Age:** **Contact No:**	
Name of Client's Partner or Spouse:		**Age:** **Contact No:**	
Legal Guardian / Main caregiver of Client:	☐ **Father** ☐ **Mother** ☐ **Others:** *Please state name, contact no. and relation to client*		

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I&R and Intake Assessment Form

CASE BACKGROUND *[For Official Use]*

Presenting Issues:**			
Reason for Referral:** (for I&R only)		**Referred to:**** (for I&R only)	

****Note for Safe Place team only - For I&R, only these fields are required to be completed.**

INTAKE ASSESSMENT

Care arrangement intentions:	☐ Unknown ☐ In Progress ☐ Self-parent ☐ Foster ☐ Adoption ☐ Abortion
Level of support from Client's Family:	Not supportive ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Extremely supportive
Level of support from Father of the child:	Not supportive ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Extremely supportive
Level of support from family of Father of the child:	Not supportive ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Extremely supportive
Current Source/s of Help for Client:	
Current Living Arrangement:	
Current Financial Situation:	

MEDICAL HISTORY

Has client seen a counselor/psychologist before? ☐ **Yes** ☐ **No**

If Yes, please list name of Counselor, Outpatient Therapy, Family Therapy, Acute in-patient hospitalizations, etc. Attach additional information if necessary.

Does client have any medical problems related to the pregnancy? ☐ **Yes** ☐ **No**

If Yes, please state. Attach additional information if necessary.

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RISK ALERT CHECKLIST

A. FAMILY VIOLENCE CONCERNS	
Level of Risk 1. Does the information presented suggest that any member in the family, including the client has been injured or is likely to be harmed or neglected (include moral risk and self-harm)*? When did abuse start? Last Incident Frequency	☐ Yes ☐ No
If Yes, please proceed to the following questions: 2. Are there visible signs of injury? 3. Was a weapon used? 4. Will the person be at risk of immediate injury/harm if their circumstances remain the same?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
Resources / Support 5. Does the present carer have the commitment, resources and capacities to protect the person now? 6. Is there anyone else in the immediate care environment of the vulnerable person who has the capacity and willingness to protect him/her?	☐ Yes ☐ No ☐ Yes ☐ No
FAMILY VIOLENCE RISK ASSESSMENT (Only if "Yes" for Qn. 1)	☐ Low ☐ Medium ☐ High

B. SUICIDE RISK ASSESSMENT	
1. Does the information presented suggest risk of suicide? *If Yes, please proceed to the following questions:*	☐ Yes ☐ No
2. Suicidal Thoughts Please indicate evidence: (Frequency, intensity, duration)	☐ Yes ☐ No
3. Suicidal Plans Please indicate evidence: (Concrete, specific, accessibility/availability)	☐ Yes ☐ No
4. Past Suicidal Attempts Please indicate evidence: (Frequency, intensity, duration)	☐ Yes ☐ No
5. Risk Factors Please indicate evidence: (Acute stressor, mental health, physical health, etc.)	☐ Yes ☐ No
6. Protective Factors Please indicate evidence: (social support, hopes, etc)	
SUICIDAL RISK ASSESSMENT (Mandatory if "Yes" for Q1)	☐ Low ☐ Medium ☐ High

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C. RISK OF HARM TO OTHERS (out of family setting) ASSESSMENT	
1. Does the information suggest that the client/family member is of danger to others (e.g physical / sexual)? *Please indicate evidence:*	☐ Yes ☐ No
RISK OF HARM TO OTHERS ASSESSMENT (Mandatory if "Yes" for Q1)	☐ Low ☐ Medium ☐ High

OVERALL RATE OF RESPONSE: ☐ Crisis (Immediate) ☐ Urgent (By the next day) ☐ Normal (within 3 working days)

Contact may be made with client/significant protective member/next of kin. Type of follow up intervention will be decided upon contact.

REMARKS:

SERVICES REQUESTED:

- ☐ Residential respite
- ☐ Casework and counselling
- ☐ Mother and baby care support
- ☐ Adoption and fostering support
- ☐ Others - please specify:

RECOMMENDATIONS:

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***APPENDIX A* – To be Completed by REFERRAL ORGANISATION**

PERSONAL DATA PROTECTION ACT CONSENT

I have obtained the consent of our client to give Safe Place permission to collect, use and disclose the information provided in this form for all purposes arising out this referral. Our client also consents to SP contacting her by telephone, or sending her phone or email messages, with regards to this referral.

Name of Referral Caseworker	
Signature / Date	
Name of Referral Organisation / Department	

***APPENDIX B* – To be Completed by CLIENT of SAFE PLACE**

1. PERSONAL DATA PROTECTION ACT CONSENT

By providing the above information contained in this form, I give Safe Place consent to collect, use and disclose the information for all purposes arising out of the request for information. I also consent for SP to contact me by telephone, or send me phone or email messages, with regards to my request.

Name of Client / Guardian	
Signature / Date	

2. INDEMNITY

I have approached Safe Place (SP) on my own accord to receive the assistance that I need in my present situation. I have not been coerced or enticed into any action leading me to contact SP. I hereby absolve SP, and its staff from any and all liability due to any accident or injury, however caused to either my child/children or myself while I am a client at SP.

Name of Client / Guardian	
Signature / Date	

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APPENDIX C [For Official Use]

FOLLOW-UP PLAN **Continue with Client Intake** ☐ **Yes** ☐ **No** Service to be provide: ☐ Residential respite ☐ Casework and counselling ☐ Mother and baby care support ☐ Adoption and fostering support ☐ Others - please specify:	**Recommended by:** Name of Caseworker: Signature: Date: **In consultation with:** Name of Snr Caseworker/Director: Signature: Date:

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