I&R and Intake Assessment Form

Date of referral:	

REFERRAL INFORMATION

Referral Organisation:			
Name of Caseworker/Referral Party's name:			
Caseworker/Referral Party's Email:		**Caseworker/ Referral Party's Contact No:**	
Relationship to Client (if not from an organisation):		**Social Report Attached:**	☐ **Yes** ☐**No**

CLIENT PARTICULARS

Given name:		**Last name:**	
Date of Birth (Date/Month/Year)**:**		**Pregnancy Stage or EDD:**	
Address (as per NRIC)**:**	Postal code:		
Address (place of stay, if different from NRIC)**:**	Postal code:		
Contact No:		**Nationality:**	
NRIC/Passport No:		**Marital Status:**	
Email Address:		**No. of children:** *(not including current pregnancy)*	
Hospital/Clinic:		**Name of Doctor:**	
Name of Client's Parent:	☐ **Father** ☐ **Mother**	**Contact No:**	
Name of Client's Partner/Spouse:		**Contact No:**	
Legal Guardian/Main caregiver of Client:	☐ **Father** ☐ **Mother** ☐ **Others:** *State name, contact no. and relation to client*		
Emergency Contact Person (if different from parent/guardian)	**Name and Contact No:**		**Relationship with Client:**

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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 ArrangementS:	
Current Financial Situation:	

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

If Yes, please list name of Counsellor, 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)*? Last known 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 services
☐ Casework and counselling
☐ Mother and baby care support
☐ Adoption and fostering support
☐ Others - please specify:

RECOMMENDATIONS:

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PERSONAL DATA PROTECTION ACT CONSENT *(To be completed by REFERRAL ORGANISATION)*

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 related to this referral. Our client also consents to Safe Place 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	

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PERSONAL DATA PROTECTION ACT CONSENT *(To be completed by CLIENT)*

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

Name of Client	
Signature / Date	

INDEMNITY *(To be completed by CLIENT)*

I have approached Safe Place 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 Safe Place. I hereby absolve Safe Place 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 Safe Place.

Name of Client / Guardian	
Signature / Date	

RESEARCH, PROGRAMME EVALUATION AND DATA USAGE *(To be completed by CLIENT)*

I understand that Safe Place is committed to providing high-quality social services and conducts programme evaluations, outcome monitoring, and research studies. To help with evaluation and improvement of Safe Place's programmes, I consent to the following:
Data Collection: My anonymized service records, session feedback, and outcomes may be securely stored and analyzed by the agency.
Voluntary Participation: I understand that my decision to allow my data to be used for research and evaluation is voluntary. If I decline to participate, my access to current and future social work services will not be affected.
Confidentiality: My personal information will remain strictly confidential and will never be shared without my explicit written consent, except as required by law.

Name of Client / Guardian	
Signature / Date	

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PARENTAL CONSENT (*To be completed by PARENT/LEGAL GUARDIAN if client is below 18 years old)*

I consent to my child/charge receiving services related to the purpose of this referral from Safe Place.

Name of Parent/Legal Guardian*	
Signature / Date	

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FOR SAFE PLACE USE ONLY

Intake Worker Full Name		**Date**	

FOLLOW-UP PLAN

Continue with Client Intake: ☐ Yes ☐No

Self-referral: ☐ Yes ☐No

AR: ☐ Yes ☐No

Evidence of Coercion: ☐ Yes (provide more info) ☐No

Service/s to be provided:
☐ Residential respite
☐ Casework and counselling
☐ Mother and baby care support
☐ Adoption and fostering support
☐ Others - please specify:

Remarks:

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