IR and Intake Assessment Form

Date of Referral / Assessment:	
Name of Case/Social Worker from Safe Place:	
SPIR No:	

If applicable:

Name of Referring Organisation/Dept:	
Name of Case/Social worker in-charge:	
Social Report Attached:	**Yes / No**

BACKGROUND OF CLIENT ***(Skip if information is provided in social report)***

Name of Client:	Mr/Mdm/Ms
Nationality:	
NRIC/Passport No:	**Age:**
Address:	
Contact No(s):	
Marital Status:	**No. of children:**
Stage of Pregnancy / Estimated Date of Delivery:	
Hospital/Clinic:	**Name of Doctor:**
Name of Client's Father:	**Age:** **Contact No:**
Name of Client's Mother:	**Age:** **Contact No:**
Legal Guardian / Main caregiver of Client:	☐ **Father** ☐ **Mother** ☐ **Other:** _____ *Please state name, contact no. and relation to client*

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INTAKE ASSESSMENT:

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

MEDICAL HISTORY

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 provided suggest that any member in the family, including the client has been injured or is likely to be harmed or neglected (include moral risk)*? • Duration*? • Frequency*? • Last Incident*?	☐ Yes ☐ No
If Yes, please proceed to the following questions: 2. Is there visible sign of injury? 3. Is 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 provide suggest risk of suicide? *If Yes, please proceed to the following questions:*	☐ Yes ☐ No
Suicidal Thoughts Please indicate evidence: (Frequency, intensity, duration [e.g. impact])	☐ Yes ☐ No
Suicidal Plans Please indicate evidence: (Concrete, specific, accessibility/availability)	☐ Yes ☐ No
Past Suicidal Attempts Please indicate evidence: (Frequency, intensity, duration)	☐ Yes ☐ No
Risk Factors Please indicate evidence: (Acute stressor, mental health, physical health, etc.)	☐ Yes ☐ No
Protective Factors Please indicate evidence: (social support, hopes, etc)	

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SUICIDAL RISK ASSESSMENT (Mandatory if "Yes" for Q1)	☐ Low ☐ Medium ☐ High

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 (Immediately) ☐ 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
- ❑ Confinement support
- ❑ Adoption and fostering support
- ❑ Others - please specify: _____

Any other notes:

APPENDIX A

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1. **PERSONAL DATA PROTECTION ACT CONSENT**

By providing the above information contained in this form, I give consent to Safe Place (SP) collecting, using and disclosing the information for all purposes arising out of the request for information and referral. I also consent to SP contacting me by telephone or sending phone or email messages to me with regards to my request.

_____

Name and Signature of Client / Guardian **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 that has brought me to 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 and Signature of Client / Guardian **Date**

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APPENDIX B [For Official Use]

PART 1. ACKNOWLEDGEMENT (to be sent to the referring organisation within 3 working days)

- ❑ Acknowledgement of receipt of the above referral from referring organisation

Name and date: _____

PART 2. STATUS OF REFERRAL (to be sent to the referring organisation within 2 weeks)

- ❑ Client has contacted Safe Place.
- ❑ Safe Place has contacted client.
- ❑ Client was uncontactable.
- ❑ Client has been given the first appointment on _____.
- ❑ Client did not turn up at the scheduled appointment.
- ❑ Client is presently receiving Safe Place's services.
- ❑ Others (please specify):_____

  _____

Name of case / social worker in-charge from Safe Place:	
Contact No:	
Email:	

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