**Disability**



Group Work Registration Form

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Group: Location: Start Date:** | | | | | | | | |
| **Referring Agency** | | | | | | | | |
| **Referral Source:** | | | | | | | | |
| **Contact Name: Phone:** | | | | | | | | |
| **Email: Fax:** | | | | | | | | |
| **Has the participant consented to this referral? Yes: No:** | | | | | | | | |
| **Primary Participant Information** | | | | | | | | |
| **First Name: Last Name:** | | | | | | | | |
| **Birthdate: Gender:** | | | | | | | | |
| **Country of Birth: Main Language Spoken:** | | | | | | | | |
| **Aboriginal: Torres Strait Islander: Both: Not Applicable:** | | | | | | | | |
| **Is a WDO Required/ Do you have a State Debt? Yes: No:** | | | | | | | | |
| **Do you have a Disability? Yes: No:** | | | | | | | | |
| **Home Phone: Mobile:** | | | | | | | | |
| **Address:** | | | | | | | | |
| **Email:** | | | | | | | | |
| **Emergency Contact Information** | | | | | | | | |
| **Name: Phone Number: Relationship:** | | | | | | | | |
| **Children** | **Information** | |  | | | | | |
| **First Name** | | **Last Name** | | | **Gender** | **Birthdate** | **Country of Birth** | **Disability** |
|  | |  | | |  |  |  |  |
|  | |  | | |  |  |  |  |
|  | |  | | |  |  |  |  |
|  | |  | | |  |  |  |  |
| **Consent Information** | | | **- To be completed on day 1 of group** | | | | | |
| I consent to the collection of my information to be used for reporting to funding bodies and for program evaluation. When data is given to funding bodies, I give consent for my data to be passed on:  With my name: Without my name: | | | | | | | | |
| I am willing to be contacted by Family Services Australia after the course is completed to give feedback to assist with evaluation of the group. This evaluation will occur 1 month, and 6 months after the group has finished.  Yes: No: | | | | | | | | |
| I consent to DSS collecting personal information from providers for storage on the DSS data exchange.  Yes: No: | | | | | | | | |
| I conscent for future contact for survey, research and/or evaluation.  Yes: No: | | | | | | | | |
| I am giving my information voluntarily: Participant signature: Date: | | | | | | | | |
| **Privacy Statement** | | | | | | | | |
| We value your personal and private information and strive to protect if at all times. In the collection, handling and storage of personal information, Family Services Australia complies with the legislative requirements of the  Commonwealth and NSW Governments related to the protection of privacy and personal information. | | | | | | | | |
| **For FSA Use Only** | | | | | | | | |
| **CDS Client ID:** | | | | **EIPP Number:** | | | **Funding Source:** | |