



Kith and Kin Association Limited

NEW CLIENT REFERRAL

Date of referral	:	____/____/____
Client Name	:	_____
Date of Birth	:	_____
Cultural background	:	_____
Primary Disability	:	_____
Secondary Disability	:	_____
Address	:	_____
	:	_____
Phone	:	_____

Referring person	:	_____
Funding source	:	<input type="checkbox"/> DSQ <input type="checkbox"/> Emergency <input type="checkbox"/> Contract <input type="checkbox"/> None <input type="checkbox"/> Other
Contact person	:	_____
Phone number	:	_____

Summary of Support Needs

Staff Male Female Either

Preferred service days and times

- Monday _____
- Tuesday _____
- Wednesday _____
- Thursday _____
- Friday _____
- Saturday _____
- Sunday _____

Service Duration

- 3-6 Months 12 Months Ongoing

Preferred Service commencement date:	____/____/____
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For Kith and Kin Administration Staff Only.

Quoted costs

Per Hour :	Extras :
Per Kilometer :	Total :