**Telephone: 1300 729 309**

**Email:** MR.CS.CSAfterHours.FKCSupportLine@csyw.qld.gov.au

|  |
| --- |
| **Carer details** |
| **Name**  |  |
| **Approval Type** **(Provisional, Kinship or Foster Carer)** |  |
| **Mobile Number** |  |
| **Home Number**  |  |

|  |
| --- |
| **Child/ren’s details** |
| **Name** | **Date of Birth**  | **Placement Type****(e.g., Emergency, respite, short-term, long-term)** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

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| --- |
| **Reason for referral** **(Please include specific identified support needs)**  |
|  |

**Is the carer aware of the referral to the Foster and Kinship Support Line?**

Yes/No

|  |  |
| --- | --- |
| **Child Safety Officer:** |  |
| **CSSC:** |  |
| **Date:**  |  |