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| Office of Professional Practice referral form |
| Community services organisation or Aboriginal community-controlled organisation |

Please refer to the Office of Professional Practice *Requesting a child protection referral form a*vailable at [Office of Professional Practice](https://www.dhhs.vic.gov.au/office-professional-practice) <https://www.dhhs.vic.gov.au/office-professional-practice>

# Your details

|  |  |
| --- | --- |
| **Date of request:** |  |
| **Name of requester:** |  |
| **Organisation:** |  |
| **Phone number:** |  |
| **Email:** |  |

# Authorisation of request

|  |  |
| --- | --- |
| **Name:** |  |
| **Title:** |  |
| **Date:** |  |

# Details of client this consultation request relates to

|  |  |
| --- | --- |
| **First name:** |  |
| **CRIS #:** |  |
| **Last name:** |  |

## Aboriginal and/or Torres Strait Islander status

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Please mark with an ‘x’** | Yes |  | No |  |

|  |  |
| --- | --- |
| **Date of birth:** |  |
| **Address where residing:** |  |
| **Placement type:** |  |
| **Name of care provider organisation if in out-of-home care** |  |
| **Type of order:** |  |

## Is the child authorised under section 18?

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Please mark with an ‘x’** | Yes |  | No |  | **Date authorised:** |  |

## Are any siblings a part of the consultation?

| # | Name | Date of birth | CRIS# |
| --- | --- | --- | --- |
| 1. |  |  |  |
| 2. |  |  |  |
| 3. |  |  |  |

# Purpose of case consultation request

|  |  |
| --- | --- |
| **In a few sentences, briefly explain what you are seeking from the OPP in relation to this client(s)** |  |

# Divisional consultation

|  |  |
| --- | --- |
| **Briefly outline any consultation you’ve had with the divisional child protection program (who and when)** |  |

[Email request to Office of Professional Practice](mailto:oppcpintake@dhhs.vic.gov.au) <oppcpintake@dhhs.vic.gov.au>

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