REFERRAL FORM

Return via Email – referrals@trauma-assist.com.au

Date: ___/___/_____

Clients name: _____ DOB: ___/___/_____ Age: _____ ☐ Male ☐ Female

Address: _____

Home Phone: _____ Mobile Phone: _____

Email Address: _____

Contact Person: _____ Relationship to Client: _____

Aboriginal/Torres Strait Islander: ☐Yes ☐No - Culturally and Linguistically Diverse:☐ Yes ☐ No

Purpose of Referral: _____
_____
_____
_____
_____
_____
_____

Please tick the boxes if the client presents with current or historical:

☐ Mental Health Concerns/Diagnosis ☐ Substance Abuse ☐ Criminal Record
☐ Suicidal Ideation ☐ Exposure to Domestic Violence ☐ Risk Taking Behaviour
☐ Problematic Sexualised Behaviours ☐Self-Harm ☐ Medical Issue ☐Disability

Please Specify if Any: _____
_____

Identified Client`s Goals: _____
_____

Preferred Counsellor Gender: ☐Female ☐Male

Preferred Office: ☐Hervey Bay ☐ Maryborough

Preferred Service Delivery Mode ☐ Face to Face ☐ Phone ☐ Tele Counselling

Is it safe to leave a message/txt to the client? ☐YES ☐ NO

Do you want to be informed should the client fail to attend the service? ☐ Yes ☐No

Does the client require an interpreter? ☐ Yes ☐ No

Referrer:_____ Agency:_____ Position: _____

Work Phone: _____ Email Address: _____