Office Use:

CAS No: \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Counsellor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Appt date / time: / / 20\_\_\_\_ & \_\_\_:\_\_\_

### Client Name: Ms/Mrs/Miss/Mr: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### DOB: \_\_\_\_\_\_ / \_\_\_\_\_/ \_\_\_\_\_\_\_\_ Male Female Other

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Post Code: \_\_\_\_\_\_\_\_\_

Ph. No(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ethnicity:** ATSI CALD OTHER

 (Aboriginal/Torres Strait Islander) (Culturally & Linguistically Diverse) (Anglo-English speaking)

Country of birth & language spoken in home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Year of arrival: \_\_\_\_\_\_\_\_\_\_ **Date of Referral**: / / 20\_\_\_\_

**Next of Kin/Parent/Carer:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ph no: (s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Which service is required:**

Family Violence Counselling Domestic Violence Advocacy

Child Sexual Assault Therapy Sexual Assault Counselling

Womens Health – Up to 6 week counselling session *(costs apply this service) $*45 for waged and $20 holder of health care card, per session.

Local Support Coordinator

Please forward the referral to Desert Blue Connect via:

 Email: info@desertblueconnect.org.au

**Has client consented to Referral?** YES / NO  **(***Please circle***)**

 **Who making this referral**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referral source requires feedback from Desert Blue Connect.: Yes / No

Are there support services currently assisting this client? Yes / No

What / who are these services: (e.g. GP/Psychologist/Psychiatrist/Central West Mental Health Services (CWMHS) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Reason for referral /brief history**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Women’s Health counselling program:** *(please circle*)

Relationship Mental health (depression/anxiety) Children/parenting

Family/ DV Sexual Assault/abuse Self-esteem/personal development

Drug/alcohol Grief and Loss

Other ***(please specify)*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Relevant medical history:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Appointment Reminder Option – usually the day prior to appoint**

Would you like a reminder for your next appointment? Yes / No

Can we leave a voice message on the phone number provided on this form? Yes / No

If your situation changes and you’d like reminder contact to stop, please notify us immediately.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, agree to appointment phone reminders.

(Please print full name)

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: / / 20\_\_\_\_\_\_