###  Date of Referral: / / 20\_\_\_\_

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

DOB: \_\_\_\_\_\_ / \_\_\_\_\_/ \_\_\_\_\_\_\_\_ (*Sex assigned at birth)* Male Female

### Gender identity: Male Female Non-binary Other

### Diversity: LGBTIQA

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

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

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ethnicity:** ATSI CALD OTHER

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

Country of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year of arrival into Australia: \_\_\_\_\_\_\_\_\_\_

Language spoken: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you require an Interpreter: Yes / No

**If safe - Do you consent to receiving text messages: Yes / No**

**Next of Kin: Husband/ Wife/ Partner / Parent / Sister / Brother / Auntie / Carer:**

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

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

**Which service is required?** *If unsure please leave blank and we will discuss this with you:*

**Free services:**

Family Violence Counselling Sexual Assault Counselling

Child Family Violence Counselling Child Sexual Assault Therapy

Domestic Violence Support and Advocacy

*(Court Support, FVRO’s*, *Long term Support*)

Rural Support Services:

***Clients residing in the Shires*** *of Morawa, Mingenew, Coorow, Yalgoo, Three Springs, Carnamah, Perenjori. (Includes: grief and loss, adolescent issues, relationship, parenting, self esteem and building confidence, mental health including anxiety and depression)*

General Nurse Consult (Geraldton) LAMP Support Service - WH

  *(Perinatal Mental Health)*

Unplanned Pregnancy Counselling Women’s Health GP 

**Low cost services:** *$45 for waged and $20 holder of health care card, per session. Payment required on day of session.*

Individual Womens Counselling (Geraldton)

*(Up to 6 weeks, includes: self esteem, confidence, stress, anxiety, depression, grief, assertiveness and personal, emotional and relationship issues)*

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person making referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agency/Contact details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_\_\_\_

Are there support services currently assisting this client, what / who are these services: (e.g. GP/Psychologist/Psychiatrist/Central West Mental Health Services (CWMHS) \_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **All clients to complete (Please circle)** |
| **Medicare No:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ IRn: \_\_\_\_ Exp date: / 20 |
| **Marital Status:** Single Married Separated/Widowed De facto Partner |
| **Employment:** Employed Yes / No Full-time Part-time/casual |
| **Low Income:** Yes / No **Parent / Carer:** Yes / No**Centrelink payment:** Yes / No**Healthcare card:** Exp date: / / 20\_\_\_**Pension concession no:** Exp date: / / 20\_\_\_ |
| **Study:** Yes / No Full-time Part-time |
| **Homeless:** Yes / No  |
| **No. of dependent children:**   | **Ages of children:**  |
| **Disability:** Yes / No **Disability categories:** Physical Sensory Psychiatric Neurological/Cognitive Intellectual  |
| **Are you a care for anyone other than dependent children:** Yes / No**Specify who:**   |

**How did you hear about us: *Please circle***

Internet search (google or similar) Facebook Website

Newspaper Radio Friends or family

Please forward the referral to Desert Blue Connect via: Email: info@desertblueconnect.org.au

**Staff use only:**

 CAS No: ­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Reconnecting Client:**  Yes / No

 **Best Practice WH Costs** :  $20  $45

Message left: \_\_\_\_ / \_\_\_/20\_\_\_ - \_\_\_\_ / \_\_\_/20\_\_\_ - \_\_\_\_ / \_\_\_/20\_\_\_

Appointment made: \_\_\_\_ / \_\_\_/20\_\_\_

No Contact: \_\_\_\_ / \_\_\_/20\_\_\_

**If safe Client consents to Text messages: \_\_\_\_ / \_\_\_/20\_\_\_ Set up SMS :** Yes / No

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

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