Desert Blue Connect

REFERRAL FORM

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 ☐ (Aboriginal /Torres Strait Islander) CALD ☐ (Culturally & Linguistically Diverse) OTHER ☐ (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 **Centrelink payment:** Yes / No **Healthcare card:** **Pension concession no:**	**Parent / Carer:** Yes / No Exp date: / / 20___ 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