

CLIENT REFERRAL FORM

Referrer name: _____ Date: _____

Referrer organisation:

- | | | |
|---|--|--|
| <input type="checkbox"/> Health agency | <input type="checkbox"/> Community services agency | <input type="checkbox"/> Education agency |
| <input type="checkbox"/> Internal | <input type="checkbox"/> Legal agency | <input type="checkbox"/> Employment/job placement agency |
| <input type="checkbox"/> Centrelink/DHS | <input type="checkbox"/> Other agency | <input type="checkbox"/> Self |
| <input type="checkbox"/> Family | <input type="checkbox"/> Friends | <input type="checkbox"/> General medical practitioner |
| <input type="checkbox"/> CoS program | <input type="checkbox"/> My Aged Care gateway | <input type="checkbox"/> Linkages program |
| <input type="checkbox"/> LAC referral | <input type="checkbox"/> NDIS referral | <input type="checkbox"/> Humanitarian Settlement program |
| <input type="checkbox"/> Other party | <input type="checkbox"/> Not stated/inadequately described | |

Referral Type:

- Phone Walk-in Email

Name of Client: Given name _____ Family name: _____

Is the client aware of the referral? Yes No

Name provided is a pseudonym

Age: _____ D.O.B: _____ Estimated D.O.B: _____

Country of Birth: _____

- Male Female Not Stated

Indigenous Status:

- Aboriginal Torres Strait Islander Both Not Stated/Inadequately Described
- CALD Disability

Residential Address:

Phone: _____

Main Language Spoken at home: _____

Parent/Carer contact details: Name: _____ Phone: _____

Present situation: (Reason for Seeking Assistance):

- | | | |
|---|---|--|
| <input type="checkbox"/> Physical health | <input type="checkbox"/> Mental health/wellbeing/self-care | <input type="checkbox"/> Personal and family safety |
| <input type="checkbox"/> Employment | <input type="checkbox"/> Family functioning | <input type="checkbox"/> Age-appropriate development |
| <input type="checkbox"/> Housing | <input type="checkbox"/> Financial resilience | <input type="checkbox"/> Education and skills training |
| <input type="checkbox"/> Community participation and networks | <input type="checkbox"/> Material wellbeing and basic necessities | |

Is the client working with another service? Yes No

If Yes, please provide details

Worker: _____ Service: _____
Phone: _____ Fax: _____

Support Provided:

Please email this referral form to Youth and Family Counselling Services:

Gloucester CC - Gloucester Youth Services
gloucesteryouthandparenting@catholiccare.org.au
OR
Maitland CC - Maitland & Dungog Youth Services
youthandfamily@catholiccare.org.au