Desert Blue Connect

REFERRAL FORM

Date of Referral: / / 20____

Client Name: Ms/Mrs/Miss/Mr: _____

DOB: _____ / _____/ _____ Male ☐ Female ☐
(Sex assigned at birth)

Gender identify: Male ☐ Female ☐ Non-binary ☐ Other ☐

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

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

Name: _____

Address: _____

Ph no: (s) _____

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 Sexual Assault Therapy ☐ General Nurse Consult (Geraldton) ☐

Child Family Violence Counselling ☐ Unplanned Pregnancy Counselling ☐

Domestic Violence Advocacy ☐ *(Court Support and FVRO's)* LAMP Support Service- WH ☐ (Perinatal Mental Health)

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)*

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)

It is standard practice that we send appointment reminders to clients the day prior to their appointment. Please advise reception if you do not wish to receive appointment reminders for safety reasons.

Reason for referral /brief history: _____

_____

Relevant medical history: _____

_____

_____

Referring agency information:

Person making referral: _____

Agency/Contact details: _____

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) _____

_____

How did you hear about us: *Please circle*

Internet search (google or similar)
Website
Radio
Referred from other agency
Other:
Please Specify: _____

Facebook
Newspaper
Recommendation from friends or family

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

Office use only:

☐ Best Practice > Notes entry ☐ CAS No: _____

☐ $20 ☐ $45 - **WH Costs**

Message left ____ / ___/20___ - ____ / ___/20___ - ____ / ___/20___
Appointment made: ____ / ___/20___
No Contact: ____ / ___/20___
Client consents to Text messages: ____ / ___/20___

Allocated Counsellor: _____
Appt date / time: / / 20____ & ___:___ am/pm