[Insert organisation name/logo]

# CLIENT REFERRAL FORM

SECTION 1. REFERRAL DETAILS

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| **Referral date** |  | **Time** |  |
| **Staff member name** |  | **Staff member Phone** |  |
| **Program/service of interest** |  | | |

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| **Referral organisation details** (*To complete only if referral from another organisation it’s been made.)* | | | |
| **Organisation name** |  | | |
| **Address** |  | | |
| **Hours of operation** |  | **Name of program** |  |
| **Contact name** |  | | |
| **Phone** |  | **Mob:** |  |
| **Client consent for referral** | **□ Yes □ No** | | |
| **Reason for referral** |  | | |
| **Issues identified by referring agency** |  | | |
| **Any risks?** | **Self-harm □ High □ Medium □ Low**  **Suicidal □ High □ Medium □ Low**  **To others □ High □ Medium □ Low** | | |

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| **Referral made by** |
| **□Phone □Face to face Other (specify):** |

SECTION 2. CLIENT CONSENT

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| **Client consent** |
| I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ understand and agree for **[insert organisation name]** to receive my personal details. I understand my involvement in this process is voluntary and I may withdraw at anytime. I also understand that I can withdraw my consent at any time. I give consent to share information relating to my treatment and needs.  **Consent type** : □Verbal - Date: \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_Time of consent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_  □Written - Time of consent:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Client signature**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ |

SECTION 3. CLIENT DETAILS

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| **Client name** |  | | **Reference #** |  |
| **Address** |  | | **Date of birth** |  |
| **Phone** |  | **Mobile** |  | |
| **Cultural background** |  | **Language spoken** |  | |
| **Interpreter required** | **□ Yes □ No** | **Gender** | **□ F □ M** | |

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| **Client emergency contact details** | | | |
| **Full name** |  | | |
| **Relationship** |  | | |
| **Address** |  | | |
| **Phone** |  | **Mobile** |  |
| **Email** |  | | |
| **Preferred method of contact** | **□ Mail □ Phone □ Mobile □ Email** | | |

SECTION 4. CLIENT INFORMATION ON REFERRAL

**🖌Note\***

This section is recommended to inform and prioritise assessment processes however organisations are encouraged to adapt the template to suit their organisational procedures.

\*Please delete note before finalising this document.

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| **Current personal situation** | | | | |
| **Summary of services and treatment** | | | | |
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| **Client lives** | **Benefits** | | **Education** | **Employment** |
| □ Alone  □ With family/carer  □ Other  Please specify: | □ Yes  □ No  If so, what type? | | □School  □University  □TAFE  □ Other  Please specify: | □Full-time  □Part-time  □Casual  □Seeking employment |
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| **Family and social support** | | | | |
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| **Health issues** | | | | |
| **Physical** | | **Mental Health** | | |
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| **Medication** | | | | |
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| **Lifestyle activities** | | | | |
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| **Legal issues** | | | | |
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SECTION 5. REFERRAL OUTCOME

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| **Referral outcome** | **Follow-up actions**  *(e.g. inform client with letter)* | **Complete** |
| **□** Organise intake process |  | **□ Yes □ No** |
| **□** Provision of service |  | **□ Yes □ No** |
| **□** Place on waiting list |  | **□ Yes □ No** |
| **□** Referral to another agency |  | **□ Yes □ No** |
| **□** Service access decline |  | **□ Yes □ No** |
| **□** Other (specify): |  | **□ Yes □ No** |

|  |  |
| --- | --- |
| **Date** |  |
| **Staff member name** |  |
| **Staff member signature** |  |