|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date of Referral:** |  | **Is client aware of referral?** | | | ☐ Yes ☐ No | | | **Is client willing to attend** | | | | ☐ Yes ☐ No |
| **Referral Type:** | ☐Walk in  ☐Phone  ☐Email  ☐ Fax | | **Referral Source:** | | ☐Self  ☐Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ☐School  ☐Friend/Family Member  ☐Service Provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |
| **Client Details** | | | | | | | | | | | | |
| **Name:** |  | | | | **Date of Birth:** | |  | | | | | |
| **Address:** |  | | | | **Place of Birth:** | |  | | | | | |
| **Suburb:** |  | | | | | **Post Code:** | | | |  | | |
| **Gender:** | ☐ Male ☐ Gender Diverse ☐ Unsure ☐ Female | | | | | | | | | | | |
| **LGBTIQ+:** | ☐ Lesbian ☐ Gay ☐ Bisexual ☐ Trans ☐ Intersex ☐ Queer    ☐ Other | | | | | | | | | | | |
| **Home Ph #** |  | | | | **Mobile Ph #** | |  | | | | | |
| **Ethnicity:** |  | | | | **Religion/Spirituality:** | | | |  | | | |
| **Health Care Card** | **No: Expiry**: | | | | | | | | | | | |
| **Medicare** | **No: Reference: Expiry:** | | | | | | | | | | | |
| **Do you suffer from any of the following health conditions?** | | | | | | | | | | | | |
| ☐ Diabetes ☐ Heart Disease ☐ Epilepsy ☐ Lung Disease  ☐ Kidney Disease ☐ Arthritis ☐ Asthma ☐ Low/high Blood Pressure  ☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | |
| **Allergies:** |  | | | | | | | | | | | |
| **Reason/s for Referral:** | ☐ Mental Health ☐ Drugs and Alcohol ☐ School/Work ☐ General Health | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| **Parent/Guardian Contact Details** | | | | | | | | | | | | |
| **Name:** |  | | **Phone:** | |  | | | | | | | |
| **Address:** |  | | **Email:** | |  | | | | | | | |
| **Relationship:** |  | | **Can we contact this person about your appointments?** | | | | | | | | ☐ Yes ☐ No | |
| **Parent/Guardian Contact Details** | | | | | | | | | | | | |
| **Name:** |  | | **Phone:** | |  | | | | | | | |
| **Address:** |  | | **Email:** | |  | | | | | | | |
| **Relationship:** |  | | **Can we contact this person about your appointments?** | | | | | | | | ☐ Yes ☐ No | |
| **GP/Psychiatrist/Counsellor Contact Details** | | | | | | | | | | | | |
| **Name:** |  | | **Phone:** | |  | | | | | | | |
| **Address:** |  | | **Email:** | |  | | | | | | | |
| **Organisation:** |  | | | | | | | | | | | |
| **Referrer’s Details** | | | | | | | | | | | | |
| **Referrer’s Details:** ☐ Same details as Emergency Contact | | | | | | | | | | | | |
| **Name:** |  | | | **Relationship:** | |  | | | | | | |
| **Address:** |  | | | **Organisation:** | |  | | | | | | |
| **Phone:** |  | | **Email:** |  | | | | | | | | |