# REFERRAL *Form*

REFERRAL IN: ☐ REFERRAL OUT: ☐

NAME OF CLIENT: ..... D.O.B: .....

AGE: ..... GENDER: .....

ATSI **YES / NO** CALD: **YES / NO**

LANGUAGE OTHER THAN ENGLISH: **YES / NO**

ADDRESS: .....

PHONE: .....

HAVE YOU RECEIVED SUPPORT FROM THIS SERVICE BEFORE? **YES / NO**

IF YES, WORKER'S NAME: .....

PRIMARY ISSUE OR CONCERN TO BE ADDRESSED: .....

CLIENT'S VIEW OF WHAT SUPPORT THEY WOULD LIKE TO RECEIVE: .....

REFERRING AGENCY: .....

NAME OF WORKER: ..... RELATIONSHIP TO CLIENT: .....

ADDRESS ..... PHONE .....

FAX: .....

*Please feel free to attach any further information regarding this referral*

## CONSENT TO RELEASE INFORMATION

I, ..... CONSENT .....

OF ..... RELEASING INFORMATION REGARDING MYSELF TO: .....

I understand that this consent will expire 12 months from the date of signing or on the termination of my contact with *(insert org name)*, whichever occurs first. I understand that I may withdraw this authorisation, in writing, at anytime prior to the expiry date, except where action has already been taken on the basis of this authorisation.

SIGNED (CLIENT): ..... DATE: ...../...../20.....

SIGNED (WORKER): ..... DATE: ...../...../20.....