Counselling and Psychological Services Referral

Details of Referring Client

Name of Client: ..... **Phone:** .....

Client D.O.B: ..... **School:** (if applicable) .....

Client Address: .....

Postal Address: (if different) .....

Is the client Aboriginal and/or Torres Strait Islander? **YES** ☐ **NO** ☐

Is the client Culturally and Linguistically Diverse? **YES** ☐ **NO** ☐

Carer's Details: (if applicable)

Name of Carer: ..... **Phone:** .....

Address of Carer: .....

Postal Address: (if different) .....

Child Referrals

If the client is a child, is the child in the care of the CEO of the Department of Communities? **YES** ☐ **NO** ☐

If yes, what period is the child in the care of the CEO for? **2 Years** ☐ **Until 18** ☐

Other Important Family Members and Relationship to Above Client

Name: ..... **Relationship:** ..... **Phone:** .....

Address: .....

Name: ..... **Relationship:** ..... **Phone:** .....

Address: .....

Name: ..... **Relationship:** ..... **Phone:** .....

Address: .....

Name: ..... **Relationship:** ..... **Phone:** .....

Address: .....

If a Genogram is available, please provide in PDF or Microsoft Word format.

If applicable, please indicate what current contact is organised for the child and their important family members:

If applicable, please provide a brief description of current case plan and concerns for client:

Drug and Alcohol Use - Do any of the referred clients have a history of drug and/or alcohol use?

If yes, please provide details:

Are there any safety concerns for providing counselling and psychological services to this client?

If yes, please provide details:

Medical History

Please identify any relevant details of medical history (including mental health history). Please also include names of organisations that engaged in service provision with the client, and approximate dates of any service provision.

Current Support

Please identify any health care service providers who are currently working with the client and their contact details:

What are the desired goals and outcomes for the client referred for Counselling and Psychological Services?

Primary Goal: .....

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Other Goals: .....

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Reports

If a report is required for a specific purpose, please provide details.

Reason for report: .....

Date report is required: .....

Please allow up to 6 weeks for reports to be finalised.

Other Relevant Information

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Referrer Details

Name of Referring Person: .....

Position: .....

Organisation: .....

Location: .....

Phone: .....

email: .....

Signature of Referrer: ..... **Date** .....

Client Consent: (To be completed by client)

Client Consent to Share information

If you would like Carnarvon Family Support Service INC. to share your information with another person or organisation, please complete the following.

Please note: If you are the legal guardian of a person or child who will receive counselling and psychological services, signing below also indicates your consent for Carnarvon Family Support Service INC. to receive and release information regarding this person or child with the people and/or organisations you list below.

I give my permission for the following people and/or organisations to release my information to Carnarvon Family Support Service INC., and for Carnarvon Family Support Service INC. to release my information to them.

Client Signature: ..... **Date** .....

Witness Signature: ..... **Date** .....

Client Consent: (To be completed by client)

Client Consent to Referral

I, ... (print your name) , consent to this referral to Counselling and Psychological Services at Carnarvon Family Support Service INC.

I also consent to being contacted by Carnarvon Family Support Service INC. for appointment organisation.

Name of the person or child in your care that this service will be provided to : (if applicable)

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Person/Child's D.O.B: ..... **Person/Child's Age:** .....

Client Signature: ..... **Date** .....