Summary and Referral Information	Client's First Name:	Surname:
	Address:	
	Mobile:	Date of Birth: / /
	Sex:	No. of Dependants (if any):

Referrer

Name: _____ Organisation: _____

Phone/Mobile: _____ Email: _____

Types of Services Required (please tick whichever is relevant)

☐ COACH Community Mentoring	☐ LifeCare Women's Centre Programs	☐ Financial Care/B Empowered
☐ Counselling & Psychological Services		☐ Others (please specify):

Presenting issue(s) as identified by the client or their representative:

Reason for referral as identified by referrer/services provider:

Description of presenting and underlying identified issues (if known by referrer)

Presenting and underlying issues:

Significant history (medical, medication issues, developmental, functional/daily living skills, social, emotional, trauma – including abuse or neglect, etc):

Other:

Social, spiritual and diversity considerations (including cultural practices, beliefs, traditions important to the client):

Alerts

Risks: (Please attach any available risk assessments)
Risk management strategies:
Access to the referred service has been discussed with the client? ☐ Yes ☐ No

Barriers to Service:
_____
Support required to address barrier to service:

Current Services - *Services used in the last twelve months: consider all health and community services.*

Agency	Record contact details or other information as appropriate (e.g. key contact)

Court and statutory orders

Mental health orders -
_____
Orders relating to children
_____
Intervention orders
_____
Guardianship and admin. Orders
_____
Other type of court or statutory orders (please specify):
_____

Office use only

Type of Referral: ☐ External ☐ Internal ☐ Self

Data collected by:_____ Signature _____
Date_____

Manager/Coordinator:_____ Signature _____
Date_____

Staff Allocated to Action: _____

Comments:

Referral Forwarded To

Date	Agency/CLL Service	Contact details	Purpose of referral